New Nouveau
Brunswick

SUMMARY REPORT

An Ounce of Prevention...

A position paper on health promotion and prevention issues

Prepared by the

PREMIER'S COUNCIL ON HEALTH STRATEGY

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A POSITION PAPER ON HEALTH PROMOTION AND PREVENTION ISSUES

Prepared by the
PREMIER'S COUNCIL ON HEALTH STRATEGY

565 Priestman Street
Fredericton, New Brunswick
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Background

The Premier's Council on Health Strategy was created by the Province of New Brunswick to provide independent advice to the government on possible future policy directions that would appropriately address the health status of our citizens. To fulfil its mandate, the Premier's Council on Health Strategy was to:

1. Advise the government on strategies that will impact positively on the health of New Brunswickers.

2. Recommend broad policy options for improving the health status of New Brunswickers. The recommended policies will be cost-effective, measurable and include policies which are beyond the traditional jurisdiction of the health sector.

3. Recommend innovative approaches to health services which:

    - are sensitive to the needs of the Province;
    - foster personal responsibility for health;
    - foster the appropriate use of resources by individuals and health professions;
    - enhance linkages between health and related human services;
    - emphasize health promotion and disease prevention.

4. Involve the public and provider groups in identifying strategies that will impact positively on the health of New Brunswickers.

5. Appoint such committees as it deems necessary to the attainment of its mandate.

6. Make periodic reports to the Government of New Brunswick.

(Further information on the Council is available on request.)

The mandate given to the Council was very broad and it would not be possible to examine every possible issue in detail during the three-year term of the Council which is to end in September of 1993. A number of topics were selected for more active research and consideration by the Council.

It was agreed by all of the members that an area of priority would be the concept of health promotion and prevention issues.

Information was gathered from a variety of sources including a literature search, personal interviews and the mailing of a detailed questionnaire. The Council has

preserved the hard data collected in a general bibliography in their library which is open to the public.

Working through a sub-committee and the full Council, a Draft Report on Health Promotion and Prevention Issues was completed by August 1991 and circulated to a large list of interested stakeholders. They were invited to submit their comments to the Council office to be considered in a final version of that report. Those who responded are listed in an appendix of the full report.

This document is intended as an executive summary of the full January 1992 version of the report which is available on request from the Council office. Readers should also remember that the document An ounce of prevention...A position paper on health promotion and prevention issues is not the Council's only final product. We will be preparing a comprehensive strategy for healthy public policy for submission to the government after further consultation with interested stakeholders.

Definitions

In preparing this position paper, we have reviewed the provincial government policy statement released in the legislative assembly in 1990 under the title **Toward a Comprehensive Health Strategy - Health 2000 - Vision, Principles and Goals**. We would draw your attention to the following key concepts outlined in that document which have also been adopted as fundamental foundations to the work of our Premier's Council on Health Strategy.

HEALTH PROMOTION

Health promotion can be defined as *"the process of enabling people to increase control over, and to improve, their health"* (World Health Organization).

HEALTH

"Health can be defined as: the capacity of the individual, group and the environment to interact with one another in ways that promote subjective well-being and allows people to cope with, adapt to, or influence the pressures of daily living. It includes the optimal development and use of abilities, at whatever level, be they physical, social or mental" (Health 2000 - Toward a Comprehensive Health Strategy, Government of New Brunswick).

A VISION OF HEALTH

"The New Brunswick Government's vision of health is one in which people will live longer in good health with fewer illnesses and disabilities, empowered to realize their full potential, through a safe, non-violent environment, with adequate income, housing, food and education; with a valued role to play in family, work and community, and with access to appropriate health and community services regardless of geography, income, language, age, gender or cultural background.

The vision of health which the Government of New Brunswick perceives is a province in which the citizens, the service providers and the Government of New Brunswick collaborate, with shared responsibility, to achieve better health for all" (Health 2000 - Toward a Comprehensive Health Strategy, Government of New Brunswick).

Guiding Principles and Health Goals

Guiding Principles

1. Provincial Planning
2. Effectiveness and Efficiency
3. Community-Based Approach
4. Health Status / Outcomes Focus
5. Shared Responsibility

Health Goals

1. To increase the number of years residents of New Brunswick live free of major disease, disability and handicap.

2. To increase emphasis on health promotion and disease prevention.

3. To achieve and maintain healthy, strong and supportive individuals, families and communities.

4. To support the creation of healthier environments for all New Brunswickers.

5. To maintain or increase the accessibility, affordability and appropriateness of health and community services for the citizens of New Brunswick.

Concepts of Health Promotion and Prevention

Canada has been recognized as a world leader in developing the theories and principles of health promotion but still needs to set a better example in making long-term commitments to consistent implementation of strategies to reduce unnecessary injuries and illnesses.

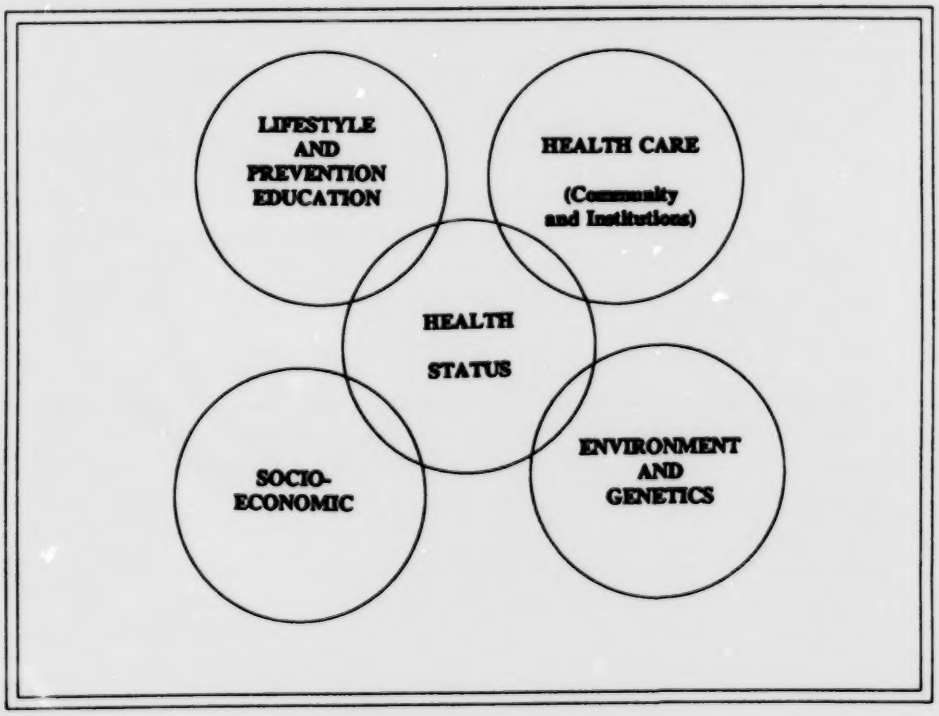
Our full document reviews such milestones as the Lalonde Report of 1974: A New Perspective on the Health of Canadians followed by the Ottawa Charter for Health Promotion in 1986 and the 1986 federal report called Achieving Health for All: A Framework for Health Promotion. These messages were brought together at the National Conference on Health Promotion and Disease Prevention held in Vancouver, B.C., in 1989.

We have noted an evolution of recognition of the factors that impact on an individual's health status. While lifestyle has a role to play, we also know that we cannot entirely blame a person for their personal level of health.

The environment, public policy and other socio-economic conditions could combine with biological and genetic traits to create barriers to one's good health.

Perhaps the following diagram developed by the Council can help to illustrate the mix of components that help determine one's health status.

SIGNIFICANT COMPONENTS THAT DETERMINE HEALTH STATUS OF NEW BRUNSWICKERS



How should we respond?

We have to recognize the negative impact of poverty, family violence, sexual abuse, chronic disability, teenage pregnancy, pressures of single parenting, substance abuse, family break-ups, illiteracy, unemployment and other social problems that require systemic changes in how our society responds to such needs. We must be committed to:

- **reducing inequities**
- **increasing the prevention effort**
- **enhancing people's ability to cope.**

Public education on health promotion and prevention must be continued across the general population but we would argue that specific prevention campaigns should be targeted to specific segments of the population who are at risk. By choosing a specific target audience for a specific prevention goal, we can then develop a strategy that can be more effective. We can also measure the degree of positive outcomes achieved.

Do we merely want lots of activity in health promotion campaigns or do we want to be selective and effective in changing some negative behaviours of our citizens?

Health status could be improved if we create a social and physical environment which enables more people to enjoy better health. Factors such as housing, employment, income, nutrition, transportation and awareness of community resources could reduce somewhat the need for access to expensive acute-care services.

We need coalitions of partner groups instead of separate positions and "turf wars" among the sectorial interests. While some are advocating a move away from growth in the institutional sector in favour of community support systems, we should recognize that institutions are part of the community and we could strengthen that community connection. For example, hospitals and nursing homes could offer more ambulatory care, screening services, adult day care, public health sessions, diabetic clinics, health worker training, etc. to balance the necessary levels of acute care services. Staff who work at institutions are also part of our community.

How we use our resources today will have an effect on how we will deal with people in the future.

Changes in our approach must be implemented wisely and evaluated constantly for results. We will need ongoing research into techniques for health

promotion and prevention initiatives, coupled with an ongoing effort to utilize the resources of all the stakeholders in a coordinated and useful manner.

The community must be involved in understanding the priorities for community health needs and how to develop the local community resources to meet local community needs.

If we are to make the most of volunteer and non-profit community resources, we must heighten the levels of mutual respect and cooperation between government at all levels and the community groups.

Summary of Recommendations

The Council identified a number of specific health problems that deserve special attention for public health promotion and prevention initiatives. They included such important issues as:

a) **Heart Health**
b) **Cancer Control**
c) **Injury Prevention**
d) **AIDS (and other sexually-transmitted diseases such as chlamydia)**
e) **Mental Health**
f) **Family Violence**
g) **Exercise**
h) **Anti-Smoking Strategy**
i) **Suicide Prevention**
j) **Spinal Cord Injuries**
k) **Head Injury Reduction**
l) **Responsible Alcohol Use Awareness**
m) **Nutrition**

- **In the full report, the Council has developed 86 recommendations to address these issues as well as reforming the current delivery mechanisms for health promotion and prevention programs.**

- A number of the recommendations touch on better use of the public school curriculum and environment to assist students and teachers in making better lifestyle choices.

- Government is asked to take a more coordinated approach to the sale of tobacco to minors and other smoking-related concerns.

- Injury prevention could be significantly improved with major potential for cost savings to the medical care system.

- Sharing of information and resources must be enhanced between government and other stakeholder groups. We cannot afford duplication and wasted efforts.

- Government and other sectors must recognize and act on socio-economic problems that lead to poor health status; i.e., poverty, family violence, inadequate housing, unemployment, illiteracy, etc. Public policy must be sensitive to the potential impact on the future health of their citizens.

- Creative use of resources through targeted programs to at-risk populations, innovative services such as community health centres and use of selective screening programs could identify and respond to many health problems before they reach an acute phase requiring more expensive solutions. Such new approaches may create other roles for different professionals such as nurses, chiropractors, nutritionists, home economists, social workers, teachers, etc.

- We must recognize the need to properly address mental health issues as well as physical health problems. Along with acute conditions, we can improve the access to appropriate rehabilitation and support services to those citizens with chronic disabilities.

The full report has recommendations to address these and other concerns.

Conclusion

The government of New Brunswick has taken an important step in recognizing the need for long-term planning to meet the challenges of providing for the current health needs of our citizens while working to improve the health status of the population for the future.

Part of the challenge for the Premier's Council on Health Strategy will be an attempt to offer advice on how to more effectively improve health status within the resources that are currently at our disposal and within the resources that we can reasonably expect to be available in the future. New Brunswick is a relatively small province in terms of population and the economic base from which we must finance our future. We will not be able to rely on the federal government, in light of the shrinking growth of transfer payments and equalization grants.

We recognize that some of our suggestions will require a renewed commitment by government and other stakeholders towards providing additional resources to implement concrete action. Such resources will have to be found by reducing or

eliminating expenditures in other program areas and by reorienting the priorities for some existing service provider professionals. We expect that investments in health promotion and prevention issues will ultimately be economically effective in reducing the current growth levels for acute and chronic care medical services.

The Premier's Council on Health Strategy will also be developing a number of other directions in consultation with the stakeholder groups and the public. We felt that we could begin this process by drawing attention to the concepts of health promotion and prevention issues. We have welcomed the public interest in this area of discussion and hope that this paper will help to stimulate the debate.

The full report **An ounce of prevention...A position paper on health promotion and prevention issues** can be obtained by contacting the Council office at:

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New Nouveau
Brunswick

RAPPORT SOMMAIRE

Mieux vaut prévenir...

Document de principe sur la promotion de la santé et questions de prévention

Préparé par le

CONSEIL DU PREMIER MINISTRE EN MATIÈRE DE SANTÉ

CNB 92007

RAPPORT SOMMAIRE

Mieux vaut prévenir...

DOCUMENT DE PRINCIPE SUR LA PROMOTION DE LA SANTÉ ET QUESTIONS DE PRÉVENTION

Préparé par le
CONSEIL DU PREMIER MINISTRE EN MATIÈRE DE SANTÉ

565, rue Priestman
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Information générale

Le Conseil du premier ministre en matière de santé fut créé par la Province du Nouveau-Brunswick aux fins de fournir des conseils indépendants au gouvernement concernant des politiques futures possibles qui addresseraient adéquatement l'état de santé de nos citoyens. Afin de remplir son mandat, le Conseil du premier ministre en matière de santé doit :

1. Conseiller le gouvernement sur des stratégies qui auront un effet positif sur la santé des Néo-Brunswickois.

2. Recommander des options de politique générale pour améliorer la santé des Néo-Brunswickois. Les politiques recommandées tiendront compte des coûts/bénéfices, offriront des résultats quantifiables, et comprendront des considérations qui dépassent la compétence traditionnelle du secteur de la santé.

3. Recommander des approches novatrices susceptibles à :

   - tenir compte des besoins de la Province;
   - favoriser la responsabilité de chacun face à la santé;
   - favoriser l'utilisation appropriée des ressources par des individus et par les professionnels de la santé;
   - renforcer les liens entre la santé et les services connexes;
   - favoriser la promotion de la santé et la prévention des maladies.

4. Amener le public et les fournisseurs de services à identifier des stratégies qui influeront positivement sur la santé des Néo-Brunswickois.

5. Nommer les comités qu'il jugera à propos pour réaliser son mandat.

6. Faire rapport périodiquement au gouvernement du Nouveau-Brunswick.

(De plus amples renseignements sur le Conseil sont disponibles sur demande.)

Le mandat du Conseil est très large, il serait donc impossible d'examiner chaque question en détails durant son terme de trois ans, qui doit se terminer en septembre 1993. Un nombre de sujets furent sélectionnés pour une recherche plus approfondie et active par le Conseil.

Tous les membres ont été d'accord pour adopter comme priorité le concept de la promotion de la santé et les questions de prévention.

Nous avons recueilli de l'information d'une variété de sources, y compris une recherche littéraire, des consultations individuelles et la distribution d'un questionnaire détaillé. Le Conseil a conservé le matériel recueilli dans une bibliographie générale dans sa bibliothèque qui est ouvert au grand public.

Un sous-comité et le Conseil au complet ont travaillé ensemble dans la préparation d'une ébauche du rapport sur la Promotion de la santé et les questions de prévention, qui fut terminée au mois d'août 1991 et circulé à un grand nombre d'intervenants intéressés. Ceux-ci furent invités à soumettre leurs commentaires au bureau du Conseil pour être considérés dans la préparation de la dernière version de ce rapport. Une liste de ceux qui ont fourni leurs commentaires se trouve en annexe au rapport.

Ce document fait lieu de la version finale du rapport de janvier 1992 qui est disponible sur demande au bureau du Conseil. Les lecteurs doivent se rappeler que le document Mieux vaut prévenir...Un document de principes sur la promotion de la santé et questions de prévention n'est pas le produit final du Conseil. Suite à d'autres consultations avec des intervenants intéressés, nous préparerons une stratégie détaillée concernant des politiques relatives à un public en santé pour présentation au gouvernement.

Définitions

Dans la préparation de ce document, nous avons repassé la déclaration de principes du gouvernement provincial présenté à l'Assemblée législative en 1990 sous le titre : **Vers une stratégie globale en matière de santé - Santé 2000 - Vision, principes et objectifs**. Nous vous prions de prêter une attention particulière aux concepts clés suivants soulignés dans ce dernier et qui ont aussi été adoptés comme principes de base pour notre travail au Conseil du premier ministre en matière de santé.

PROMOTION DE LA SANTÉ

La promotion de la santé désigne *«la démarche qui permet aux personnes de mieux gérer leur santé et de l'améliorer»* (Organisation mondiale de la santé).

SANTÉ

«On peut définir la santé comme la capacité de l'individu, du groupe et de l'environnement à agir en synergie pour promouvoir le bien-être subjectif et permettre aux gens de supporter les pressions de la vie quotidienne, de s'y adapter, ou de les modèler. Cette définition de la santé tient compte du développement optimal et de l'utilisation maximale des capacités, aussi bien physiques que sociales ou mentals» (Santé 2000 - Vers une stratégie globale en matière de santé, Gouvernement de Nouveau-Brunswick).

UNE CERTAINE VISION DE LA SANTÉ

«La santé, telle que la conçoit le gouvernement du Nouveau-Brunswick, signifie : vivre plus longtemps en bonne santé, avoir moins de maladies et de handicaps et pouvoir réaliser pleinement son potentiel dans un environnement sans risque, non violent, et avoir un revenu suffisant, un logement, de la nourriture et de l'instruction. Le rôle de l'individu dans la famille, au travail et dans la collectivité sera valorisé et il aura accès aux services de santé et aux services communautaires quels que soient l'endroit où il habite, son revenu, sa langue, son âge, son sexe ou son milieu culturel.

Dans cette vision de la santé du Gouvernement du Nouveau-Brunswick les citoyens, les fournisseurs de service et le gouvernement provincial collaborent et se partagent les responsabilités pour améliorer la santé de chacun.» (Santé 2000 - Vers une stratégie globale en matière de santé, Gouvernement du Nouveau-Brunswick).

Principes directeurs et objectifs en matière de santé

Principes directeurs

1. La planification provinciale
2. L'efficacité
3. L'approche communautaire
4. La santé en général / l'accent sur les résultats
5. Le partage des responsabilités

Objectifs en matière de santé

1. Augmenter le nombre d'années durant lesquelles les résidents du N.-B. vivent sans maladies, invalidités ou handicaps majeurs.

2. Promouvoir davantage la santé et prévenir la maladie.

3. Développer et maintenir des personnes, des familles et des communautés qui soient saines, fortes et solides.

4. Favoriser la création d'environnements plus sains pour tous les Néo-Brunswickois.

5. Maintenir et accroître l'accessibilité physique et financière aux services de santé et aux services communautaires au Nouveau-Brunswick. Aussi, s'assurer que ces services soient bien adaptés aux besoins réels des populations concernées.

Concepts de promotion de la santé et prévention

Le Canada est reconnu comme un leader mondial dans le développement de théories et de principes en promotion de la santé, mais a toutefois besoin de montrer un meilleur example dans l'engagement à long terme d'une mise en oeuvre de stratégies pour la diminution de blessures et de maladies évitables.

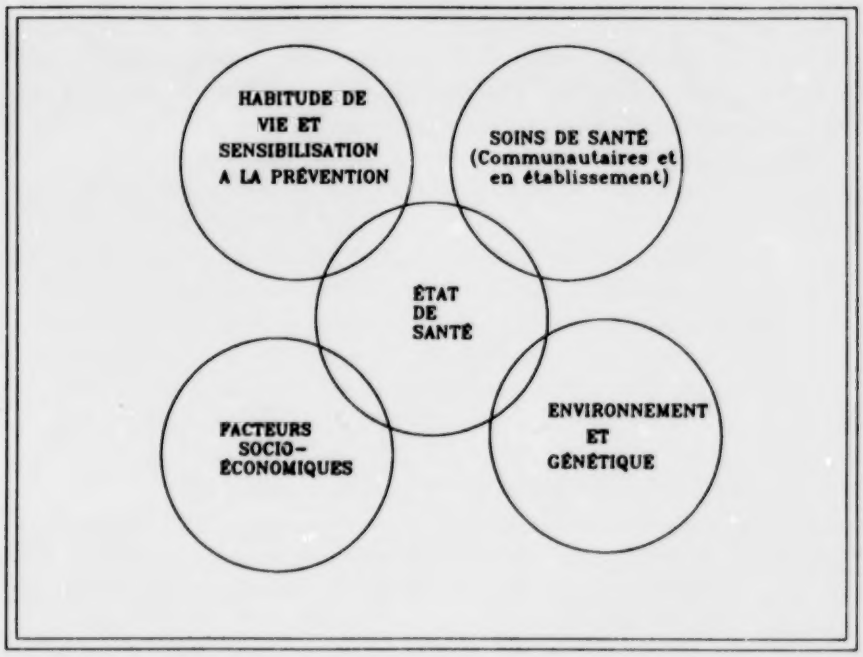
Notre rapport complet revoit des documents importants tels que le Rapport Lalonde de 1974 : Nouvelle perspective de la santé des Canadiens suivi par la Charte d'Ottawa pour la promotion de la santé en 1986 et le rapport fédéral de 1986 intitulé La Santé pour tous : plan d'ensemble pour la promotion de la santé. Ces messages furent rassemblés à la Conférence nationale sur la promotion de la santé et la prévention de la maladie tenue à Vancouver, Colombie-Britannique en 1989.

Nous avons constaté une évolution de la reconnaissance des facteurs qui ont un effet sur l'état de santé d'un individu. Quoique les habitudes de vie d'une personnne jouent un rôle ici, nous ne pouvons tout de même pas la blâmer entièrement pour son état de santé.

L'environnement, les politiques publiques et d'autres conditions socio-économiques peuvent se combiner avec les traits biologiques et génétiques pour créer des obstacles à la santé.

Le diagramme suivant, développé par le Conseil, pourrait peut-être aider à mettre en lumière la variété des facteurs qui aident à déterminer l'état de notre santé.

FACTEURS IMPORTANTS QUI DÉTERMINENT L'ÉTAT DE SANTÉ DES NÉO-BRUNSWICKOIS


HABITUDE DE VIE ET SENSIBILISATION A LA PRÉVENTION
SOINS DE SANTÉ (Communautaires et en établissement)
ÉTAT DE SANTÉ
FACTEURS SOCIO-ÉCONOMIQUES
ENVIRONNEMENT ET GÉNÉTIQUE

Comment devrions-nous réagir?

On doit reconnaître l'effet négatif de la pauvreté, la violence familiale, l'agression sexuelle, les handicaps chroniques, les grossesses chez les adolescentes, les tensions envisagées par les familles monoparentales, la pharmacodépendance, l'analphabétisme, le chômage et d'autres problèmes sociaux qui nécessitent des changements systématiques dans la manière dans laquelle notre société répond à de tels besoins. Nous devons être engagés à :

- **réduire les inégalités**
- **accroître les efforts de prévention**
- **accroître la capacité des personnes de faire face aux difficultés.**

L'éducation publique envers la promotion d'habitudes de vie saines et d'une bonne santé doit être poursuivie au sein de la population. Toutefois, nous ferions valoir que des campagnes de prévention particulières devraient cibler des secteurs précis de la population à risque. Si nous choisissons un groupe cible pour un

objectif de prévention particulier, nous pouvons ensuite élaborer une stratégie plus efficace et mesurer les résultats positifs.

Voulons-nous tout simplement lancer de nombreuses campagnes de promotion de la santé ou visons-nous à être sélectifs et efficaces pour modifier le comportement négatif de nos citoyens?

On pourrait améliorer l'état de santé en créant un environnement physique et social qui permet à un plus grand nombre de gens de jouir d'une meilleure santé. Les facteurs tels que le logement, l'emploi, le revenu, la nutrition, le transport et la sensibilisation aux ressources communautaires pourraient réduire quelque peu le besoin de services de soins pour maladies aiguës coûteux.

Il nous faut des coalitions de groupes de partenaires plutôt que des positions divergentes et des «guerres» entre les intérêts sectoriels distincts. Quoique certains revendiquent un éloignement de la croissance dans le secteur institutionnel en faveur des systèmes de soutien communautaires, nous devons reconnaître que les institutions font partie de la communauté et que ce lien communautaire pourrait être renforcé. Par exemple, les hôpitaux et les foyers de soins pourraient offrirent davantage de soins ambulatoires, de services de dépistage, de garde de jour pour adultes, de sessions en santé publique, de cliniques pour diabétiques, de formation pour les professionnels de la santé, etc. afin de trouver un équilibre au sein des niveaux en soins de courte durée nécessaires. Le personnel qui travaille en institution fait aussi partie de notre communauté.

La méthode actuelle d'utiliser nos ressources aura un effet sur notre façon de traiter les gens à l'avenir.

Il faut implanter les changements dans notre approche avec sagesse et mesurer constamment les résultats. Nous devons effectuer de la recherche continue sur les techniques de promotion de la santé et les mesures de prévention connexe à un effort continue vers une utilisation coordonnée et utile des ressources de tous les intervenants.

La communauté doit essayer de comprendre les priorités des besoins de la communauté en matière de santé et comment développer les ressources de la communauté locale afin de recontrer les besoins de cette communauté.

Si nous voulons utiliser aux mieux les ressources communautaires bénévoles ou à but non-lucratif, nous devons rehausser les niveaux de respect mutuel et de collaboration entre le gouvernement, à tous niveaux, et les groupes communautaires.

Sommaire des recommandations

Le Conseil a identifié un nombre de problèmes spécifiques de santé qui méritent une attention particulière en initiatives publiques en promotion de la santé et prévention. Ceux-ci comprennent d'importants sujets tels que les suivants :

a) **Santé cardiaque**
b) **Lutte contre le cancer**
c) **Prévention des blessures**
d) **SIDA (et d'autres maladies transmises sexuellement, telles que le clamydia)**
e) **Santé mentale**
f) **Violence familiale**
g) **Exercice**
h) **Stratégie contre l'usage du tabac**
i) **Prévention du suicide**
j) **Blessures à la colonne vertébrale**
k) **Réduction des blessures à la tête**
l) **Responsabilité en matière de sensibilisation à l'usage de l'alcool**
m) **Nutrition**

- **Dans son rapport, le Conseil a exposé 86 recommandations pour aborder ces questions ainsi que pour réformer les présents mécanismes de livraison des programmes en promotion de la santé et de prévention.**

- Certaines de ces recommandations abordent le sujet d'une meilleure utilisation des programmes d'études et de l'environnement scolaires qui aiderait aux étudiants et aux enseignants à faire des meilleurs choix concernant leurs habitudes de vie.

- On demande au gouvernement d'entreprendre une approche plus innovatrice au sujet de la vente du tabac aux mineurs et aux autres questions reliées au tabagisme.

- La prévention des blessures pourrait être considérablement améliorée, ce qui pourrait amener des épargnes au sein du système médical de santé.

- Le partage d'information et de ressources entre le gouvernement et d'autres intervenants intéressés doit être amélioré. On ne peut pas permettre la duplication inutile et les efforts perdus.

- Le gouvernement et les autres secteurs doivent reconnaître les problèmes socio-économiques qui peuvent amener un faible état de santé, tels que la pauvreté, la violence familiale, l'habitation, le chômage, l'analphabétisme, etc. et agir pour

les remédier. Les politiques générales doivent être sensibles aux effets possibles sur l'état de santé des citoyens.

- Une utilisation créative des ressources, par l'entremise de programmes s'adressant aux populations à risque, de services innovateurs tels que les centres de santé communautaires et à l'utilisation de programmes sélectifs de dépistage, pourrait identifier et répondre à beaucoup de problèmes de santé avant qu'ils ne se rendent à un stage aïgues qui nécessiterait des solutions plus coûteuses. De telles nouvelles approches pourraient possiblement créer d'autres rôles pour les professionnels tels que les infirmières, les chiropracticiens, les nutritionnistes, les économistes familiales, les travailleurs sociaux, les enseignants, et autres.

- Nous devons reconnaître le besoin d'entamer les questions de santé mentale ainsi que les problèmes de santé physique. De même que pour les conditions aïgues, l'accès à une réadaptation appropriée et à des services d'appui pour les citoyens ayant un handicap chronique, pourrait être améliorée.

Le rapport complet contient des recommandations qui abordent ces questions d'intérêt et autres.

Conclusion

Le gouvernement du Nouveau-Brunswick a réalisé un pas important, en reconnaissant le besoin d'une planification à long-terme pour surmonter les défis que posent les besoins actuels en soins et services de santé, tout en travaillant pour assurer une meilleure santé pour la population future.

Une partie du défi que confronte le Conseil du premier ministre en matière de santé sera d'offrir des conseils sur les façons d'améliorer la santé à l'intérieur des paramètres imposés par les ressources présentement disponibles et de celles anticipées pour l'avenir. Le Nouveau-Brunswick est une province relativement petite en terme de sa population et de sa base économique par laquelle nous devons financer notre avenir. Il ne sera plus possible de nous fier au gouvernement fédéral, vu la diminution croissante des payments de transferts et des subventions de péréquations.

Nous comprenons que la réalisation concrète de certaines de nos recommendations demandera un engagement renouvelé de la part du gouvernement et des autres groupes intéressés, à fournir des ressources accrues. Ces ressources devront être obtenues par la réduction ou l'élimination des dépenses au sein d'autres programmes et par la réorientation des priorités de certains fournisseurs professionnels. Nous nous attendons que cet investissement en promotion de la santé et en prévention saura, à la fin, être économiquement efficace dans la

réduction de la présente croissance des services médicaux chroniques et de courte durée.

De plus, en consultation avec les groupes intéressés et le grand public, le Conseil du premier ministre en matière de santé développera un certain nombre de directions additionnelles. Nous avons pensé démarrer ce processus en nous penchant sur les concepts de la promotion de la santé et les questions de prévention. Nous avons apprécié l'intérêt du public dans ce domaine d'étude et espérons que ce document sollicitera la discussion.

On peut se procurer le rapport complet **Mieux vaut prévenir... Un document de principes sur la promotion de la santé et questions de prévention** en contactant le bureau du Conseil au :

Conseil du premier ministre en matière de santé
565, rue Priestman, Pièce 304
Fredericton (Nouveau-Brunswick)
E3B 5X8

Téléphone : (506) 457-4819
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New Nouveau
Brunswick

An Ounce of Prevention...

A position paper on **health promotion and prevention issues**

Prepared by the

PREMIER'S COUNCIL ON HEALTH STRATEGY

An Ounce of Prevention...

A POSITION PAPER ON HEALTH PROMOTION AND PREVENTION ISSUES

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PREMIER'S COUNCIL ON HEALTH STRATEGY

565 Priestman Street
Fredericton, New Brunswick
E3B 5X8

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"The whole world gains if children grow up healthy, capable and ready to work for the good of their neighbour."

- Eglantyne Jebb

"If I had known that I was going to live this long, I would have taken better care of myself."

- Unknown

"Not everything that counts can be counted. Not everything that can be counted counts."

- Dr. Charles Garfield

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I. Premier's Council on Health Strategy - Who We Are

The Council's Mission

The mission of the Premier's Council on Health Strategy is to provide leadership and guidance to government as a whole by advising it on broad policies which will achieve health for the citizens of New Brunswick.

How the Council Evolved

The Premier's Council on Health Strategy was established by the Premier in response to the McKelvey-Levesque Report of the Commission on Selected Health Care Programs (1989).

The Council's Guiding Principles

The Council's work will be guided by the following principles:

- to provide a provincial planning framework ensuring equitable access to services;
- to provide citizens with a range and quality of services which maximize the effectiveness and efficiency of our resources;
- to place greater emphasis on community-based service delivery;
- to shift from a process or program focus to an **outcomes** focus where health status improvements can be measured;
- to work together and share responsibility among government, users and providers for achieving health.

The Council's Mandate

The Premier's Council on Health Strategy will:

- consider broad approaches for the future direction of health policy in New Brunswick;
- identify priorities for action to improve health;
- build consensus for change, in partnership with health care providers and community representatives;
- report to the Cabinet.

To fulfil its mandate, the Premier's Council on Health Strategy will:

1. Advise the government on strategies that will impact positively on the health of New Brunswickers.

2. Recommend broad policy options for improving the health status of New Brunswickers. The recommended policies will be cost-effective, measurable and include policies which are beyond the traditional jurisdiction of the health sector.

3. Recommend innovative approaches to health services which:

   - are sensitive to the needs of the Province;
   - foster personal responsibility for health;
   - foster the appropriate use of resources by individuals and health professions;
   - enhance linkages between health and related human services;
   - emphasize health promotion and disease prevention.

4. Involve the public and provider groups in identifying strategies that will impact positively on the health of New Brunswickers.

5. Appoint such committees as it deems necessary to the attainment of its mandate.

6. Make periodic reports to the Government of New Brunswick.

The Council's Membership

The Council's diverse membership reflects its broad mandate and the concept of health it embraces.

The sixteen-member Council is chaired by the Premier, with the Minister of Health and Community Services as vice-chair. The Deputy Minister of Health and Community Services is secretary to the Council. Other members include three ministers of departments which impact on health, five persons with experience in a health-related field and five consumer representatives not from health-related professions. Service provider and consumer appointments for the three-year mandate were made by the Premier through a public nomination process.

For more information, please contact the office at:

Premier's Council on Health Strategy
565 Priestman Street, Suite 304
Fredericton, New Brunswick E3B 5X8

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II. Council's Research Methodology

The staff at the Council have made a concerted effort to develop a wide range of information contacts to understand health promotion and prevention trends in New Brunswick and elsewhere.

Inquiries were made to various government departments and health-related organizations for reports and/or interviews as to current services and priorities related to our topic. A detailed questionnaire was distributed to a number of groups and associations to seek their opinions on **Prevention and Promotion of Healthy Lifestyles - Questions for Community Groups**. (See Appendix I for the sample survey and a general summary of responses received.)

We apologize to those groups who were not contacted in the first mailing. We appreciated the interest shown by those who did reply and the others who responded after the draft report was released in the fall of 1991.

We have provided a general list of the departments, groups and individuals who responded to our survey or who were consulted and/or those who made submissions for this report (see Appendix II).

We have also supplemented these contacts with a literature search, review of external reports, articles in the print media, newsletters, journals and assessments of internal documentation provided from government sources. Council maintains a general bibliography of significant public documents in our files which is available on request.

The Council members have also contributed their expertise and networks to provide helpful comments in shaping this document.

Please note that this is not the Council's final product, as we will be preparing a comprehensive strategy for healthy public policy for submission to government after further consultation with the interested stakeholders.

III. Introduction

The government of New Brunswick has taken an important step in recognizing the need for long-term planning to meet the challenges of providing for the current health needs of our citizens while working to improve the health status of the population for the future.

Canada and New Brunswick have enjoyed an excellent standard of health services in the past, but we are at a critical point in being able to maintain our current health service system. The economic realities faced by the federal and provincial governments have begun to put a significant squeeze on matching expectations with the ability and willingness to pay.

Medicare has been a tremendous asset to our population, but has also fostered a potential lack of consumer and service provider responsibility with its message of "free" health services for all. We have witnessed tremendous levels of growth in the health sector expenditures that have been disproportionate to the growth of our population or improvements in health status.

Part of the challenge for the Premier's Council on Health Strategy will be an attempt to offer advice on how to more effectively improve health status within the resources that are currently at our disposal and within the resources that we can reasonably expect to be available in the future. New Brunswick is a relatively small province in terms of population and the economic base from which we must finance our future. We will not be able to rely on the federal government, in light of the shrinking growth of transfer payments and equalization grants.

The Premier's Council on Health Strategy will be developing a number of positions in consultation with the stakeholder groups and the public. We felt that we could begin this process by drawing attention to the concepts of health promotion and prevention issues. We have welcomed the public interest in this area of discussion and hope that this paper will help to stimulate the debate.

We recognize that some of our suggestions will require a renewed commitment by government and other stakeholders towards providing additional resources to implement concrete action. Such resources will have to be found by reducing or eliminating expenditures in other program areas and by reorienting the priorities for some existing service provider professionals. We expect that investments in health promotion and prevention issues will ultimately be economically effective in reducing the current growth levels for acute and chronic care medical services.

In preparing this position paper, we have reviewed the provincial government policy statement released in the legislative assembly in 1990 under the title **Toward a Comprehensive Health Strategy - Health 2000 - Vision, Principles and Goals**. We would draw your attention to the following key concepts outlined in that document which have also been adopted as fundamental foundations to the work of our Premier's Council on Health Strategy.

HEALTH PROMOTION

Health promotion can be defined as *"the process of enabling people to increase control over, and to improve, their health"* (World Health Organization).

HEALTH

"Health can be defined as: the capacity of the individual, group and the environment to interact with one another in ways that promote subjective well-being and allows people to cope with, adapt to, or influence the pressures of daily living. It includes the optimal development and use of abilities, at whatever level, be they physical, social or mental" (Health 2000 - Toward a Comprehensive Health Strategy, Government of New Brunswick).

A VISION OF HEALTH

"The New Brunswick Government's vision of health is one in which people will live longer in good health with fewer illnesses and disabilities, empowered to realize their full potential, through a safe, non-violent environment, with adequate income, housing, food and education; with a valued role to play in family, work and community, and with access to appropriate health and community services regardless of geography, income, language, age, gender or cultural background.

The vision of health which the Government of New Brunswick perceives is a province in which the citizens, the service providers and the Government of New Brunswick collaborate, with shared responsibility, to achieve better health for all" (Health 2000 - Toward a Comprehensive Health Strategy, Government of New Brunswick).

As we develop our position to provide specific recommendations to the province, we shall also be trying to work within the framework of the principles and goals listed in that same policy statement. They can be summarized by the following:

GUIDING PRINCIPLES

1. PROVINCIAL PLANNING

(with appropriate responsiveness to regional and local needs)

2. EFFECTIVENESS AND EFFICIENCY

3. COMMUNITY-BASED APPROACH

4. HEALTH STATUS / OUTCOMES FOCUS

(move from process/program orientation to results orientation)

5. SHARED RESPONSIBILITY

(consumers must make informed choices and consider alternatives)

HEALTH GOALS

1. To increase the number of years residents of New Brunswick live free of major disease, disability and handicap.

2. To increase emphasis on health promotion and disease prevention.

3. To achieve and maintain healthy, strong and supportive individuals, families and communities.

4. To support the creation of healthier environments for all New Brunswickers.

5. To maintain or increase the accessibility, affordability and appropriateness of health and community services for the citizens of New Brunswick.

(See next page for explanation of health goal #5.)

HEALTH GOALS (cont'd)

- To do this, community-based services must be strengthened to ensure that costly institutional and residential services are only used when appropriate.

- The Department of Health and Community Services must provide leadership in the development, implementation, delivery and evaluation of an accessible, affordable and appropriate health delivery system for all.

- Planning of supply, distribution and organization of resources is needed so effective services are provided while recognizing a need to rationalize care on the basis of need.

- Barriers to health must be reduced, access improved and range of services and human resources equitably distributed.

- Focus on health outcomes and the appropriate mix and use of resources is essential.

- Attention to the needs in two official languages is required to achieve an equitable distribution of service in all areas of the province.

IV. Background

The concept of health promotion has been given a lot of attention in Canada over the last two decades but perhaps it is time to give a higher priority to strategies that can help reduce unnecessary incidence of health problems.

While few would argue that our health system has become very expensive to deliver, we have continued to place the emphasis on treating the sick rather than effectively promoting healthy lifestyles to segments of our population that are at increased risk of developing disease or having a preventable accident.

Canada has been recognized as a world leader in developing the theories and principles of health promotion but still needs to set a better example in making a long-term commitment to implementing strategies that can be proven to work in reducing accidents or illnesses in terms of actual numbers and/or at least the degree of severity.

The federal government has taken the lead in the past in developing the parameters for health promotion beginning with the famous **Lalonde Report of 1974: A New Perspective on the Health of Canadians**. This report pointed out that a number of factors could influence a person's health. These factors were outlined as:

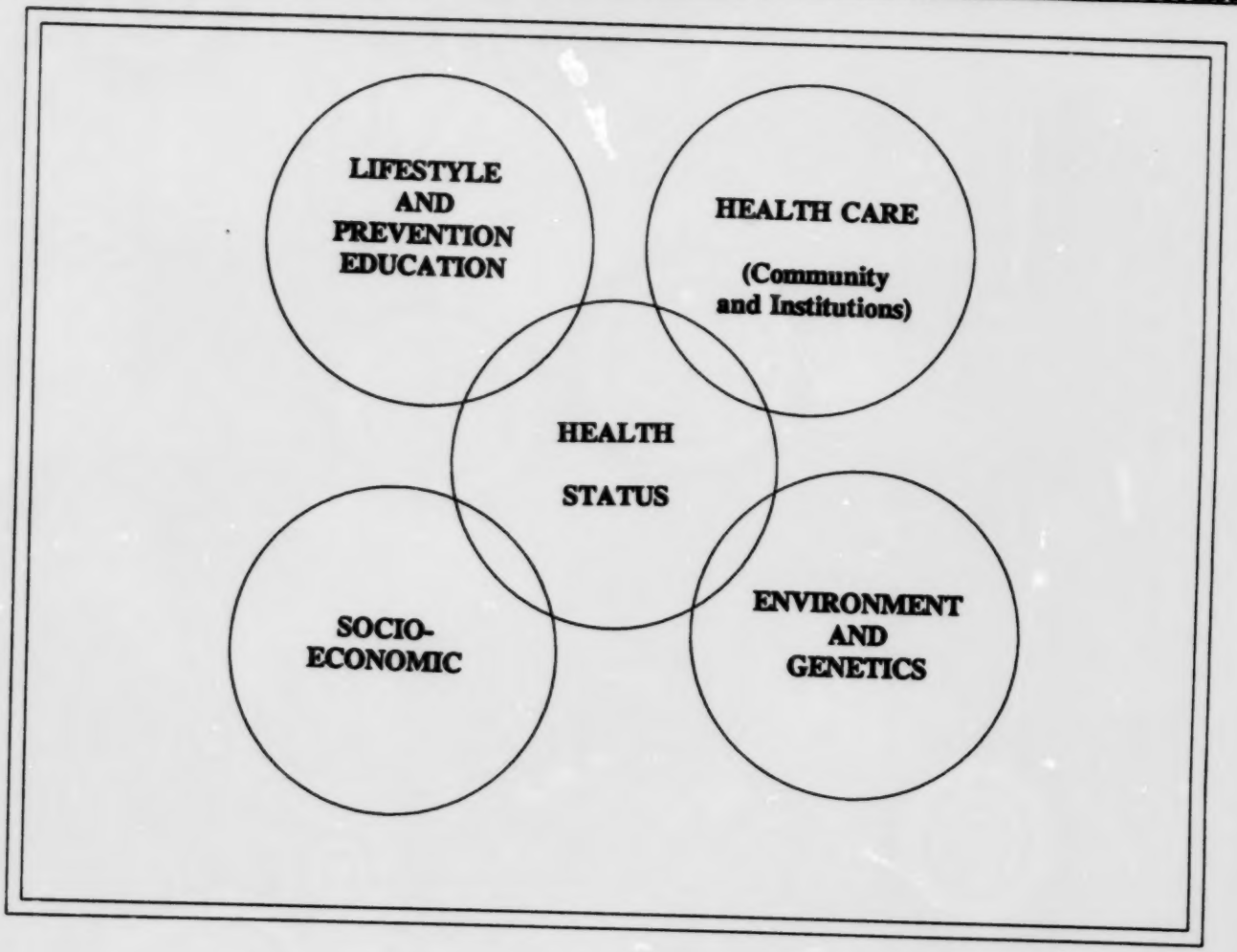
- lifestyle
- human biology
- organization of health care
- social and physical environment.

The report gave emphasis at first to the concept of lifestyle as being the dominant feature, with an implied message that individuals could control their health status. Continuing to put dollars into the health care system would not measurably improve the overall health status of the population at large. Citizens should be given responsibility for reducing risk taking activities and improving their individual lifestyle.

As the country moved into the 1980's, it became obvious that the environment in which a person functioned would also affect their potential for enjoying good health. Socio-economic factors were part of that physical environment. Poverty, education, housing, family violence, employment options and many other factors must be considered when we evaluate a person's potential to enjoy a healthy life.

Our Council has developed the graphics on the following pages to illustrate the significant components that determine our health status.

SIGNIFICANT COMPONENTS THAT DETERMINE HEALTH STATUS OF NEW BRUNSWICKERS



The significant components that determine health status include these examples and other specific factors:

LIFESTYLE AND PREVENTION EDUCATION

Lifestyle (fitness, nutrition, substance abuse)
Use of Leisure Time
Safety (occupational and personal)
Education (school/general)
Pre-Natal and Post-Natal Care
Immunization
Screening
Public Health
Mental Health

HEALTH CARE

Institutional
Community Support Services
Medical
Rehabilitation
Human Resources
Acute Care
Chronic Care
Medical Transports
Relief Services
Alternative Health Services

SOCIO-ECONOMIC

Economy
Public Attitude/Expectations
Family
Employment
Government Policy
Income Supports
Education/Training
Housing
Transportation
Social Services
Literacy
Poverty

ENVIRONMENT AND GENETICS

Water Quality
Land Quality
Air Quality
Heredity Traits
Genetic Testing/Counselling

If individuals are to make wise choices about their lifestyle, they must be convinced that they will enjoy a better quality of life and not just a longer life as a consequence of their actions.

We must create an environment in which public policies support situations in which individuals can maximize positive choices and positive behaviours.

The **Ottawa Charter for Health Promotion** of November 1986 outlined an approach to more effective health promotion. It focused on the concepts of:

- **strengthening community action**
- **developing personal skills**
- **creating supportive environments**
- **reorienting health services**
- **building healthy public policy.**

*** *We began to see a shift away from an over-reliance on the medical model of health and the prospect of blaming the victim for being the cause of their poor health status.*

Similar messages were included in the federal government document in 1986 released by the federal Minister of National Health and Welfare. **Achieving Health for All: A Framework for Health Promotion** indicated there were three national health challenges:

- **reducing inequities**
- **increasing the prevention effort**
- **enhancing people's ability to cope.**

These concepts were further strengthened at the **National Conference on Health Promotion and Disease Prevention held in Victoria, B.C.** in March of 1989. It was clear that a movement was underway to encourage the placement of health promotion on public and political agendas. The goal would be to achieve more equity in health status by empowering consumers and increasing inter-sectorial cooperation among all of the stakeholders.

Promotion of healthy lifestyle and good health must be continued across the population. However, we can argue that specific prevention campaigns should be targeted to specific segments of the population who are at risk. By choosing a specific target audience for a specific prevention goal, we can then develop a strategy that can be more effective and we can measure the degree of positive outcomes achieved.

We have to recognize the negative impact of poverty, family violence, sexual abuse, chronic disability, teenage pregnancy, single parenting, substance abuse, family break-ups, illiteracy, unemployment and other social problems that require systemic changes in how our society responds to such needs.

It would seem that many current health promotion and/or prevention programs do not necessarily reach the audience for whom the message is intended. The format of the material and the distribution network used may not reach those at risk until it is too late, if it reaches them at all. Health education must be delivered in an appropriate format at an appropriate time before the consumer has established patterns of habitual behaviour. We should get smarter in utilizing motivational and advertising techniques in our educational programs to reach our audience without being judgmental and assigning the blame to the victim.

Do we want to have lots of activity in health promotion campaigns or do we want to be selective and effective in changing negative behaviour of our citizens? How can we get better results with the resources we have?

For example, allowing the drunk driver to get out on the highway and have an accident involving innocent people and then charging him with drunk driving is not effectively preventing the accident. Spending thousands of dollars on fancy brochures will not be effective approaches to educate persons at risk if they cannot read.

The concept of individual human rights and self choices must also be coupled to responsibilities for the health of others and a recognition of the costs to the community as a whole for unhealthy consequences. Should we allow smokers to enjoy a cigarette in a restaurant or at their work site and subject their seated neighbour or co-worker to the hazards of second-hand smoke? How do we balance the ethics of confidentiality with the patient who tests positive for HIV and yet refuses to take precautions for safe sex or to inform their partners about the virus? Do we allow people to wear their seatbelt or not as a matter of personal choice? How do we protect the unborn baby from a mother who smokes, drinks and/or takes illicit drugs during pregnancy, putting the fetus at great risk?

Health status could be improved if we create a social and physical environment which enables more people to enjoy better health. Factors such as housing, employment, income, nutrition, transportation and awareness of community resources could reduce the need for access to expensive acute-care services of the formal medical system.

Public policy must be continually examined and coordinated from the perspective of its potential impact on health. The partnerships between the three levels of government must be made stronger to provide for a continuity and consistency of approaches.

Community resources such as businesses, service clubs, schools, churches, hospitals, nursing homes, volunteer bureaus, advocacy organizations, local health service professionals and others must work together to reinforce the concept of healthy communities.

We need coalitions of partner groups instead of separate positions and "turf wars" among the sectorial interests. While some are advocating a move away from growth in the institutional sector in favour of community support systems, we should recognize that institutions are part of the community and we could strengthen that community connection. For example, hospitals and nursing homes could offer more ambulatory care, screening services, adult day care, public health sessions, diabetic clinics, health worker training, etc., to balance the necessary levels of acute care services. Staff who work at institutions are also part of our community.

How we use our resources today will have an effect on how we will deal with people in the future. Reducing smoking and improving emphasis on reducing heart health risk factors may take 10-20 years to be able to clinically prove that we have been significantly successful in reducing premature heart attacks, strokes and lung cancer. Each day that we wait now increases the cost of acute care and spin-off costs for unnecessary serious health problems down the road.

Spending more money on new hospital beds, nursing homes and high technology may do little to change the health status or quality of life. We now diagnose some problems earlier which could lead to better management of the condition and a possible cure. Other patients are kept alive with technology to be alive longer, but not necessarily "live" longer. We need to seek better assessments of the value of certain technology and treatment modalities before we rush to equip each hospital with the latest gadget or pill. Should we unnecessarily extend the lives of obviously terminally ill patients with expensive heroic means? We should also consider the quality of life for individuals left in extended care wards in the hospital because they have no place to go. We will always need some hospital and nursing home beds, but perhaps we should think more clearly about how many and where they should be located to meet the real needs for the province.

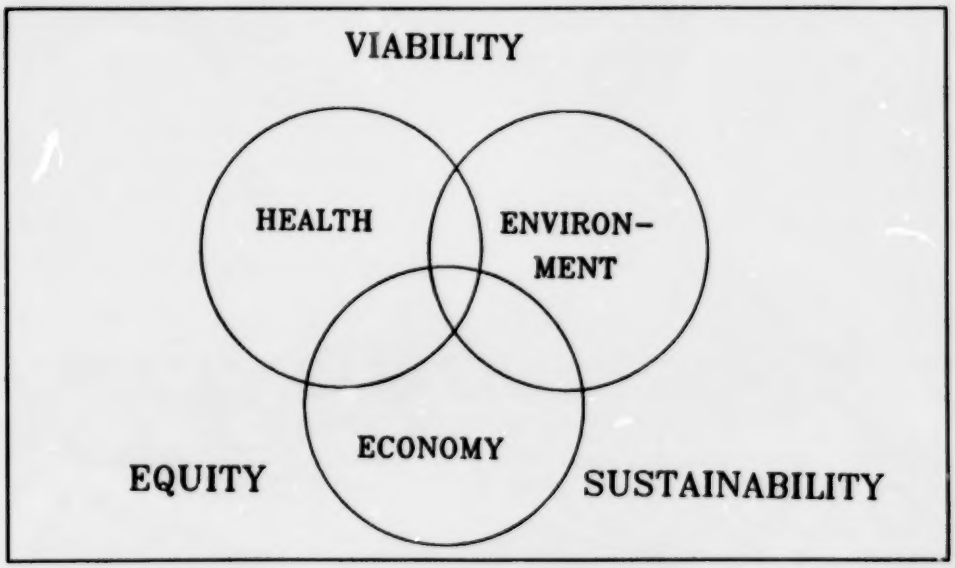
Changes in our approach must be implemented wisely and evaluated constantly for results. If we rush too quickly into too many directions, we may not know what works and what did not.

We will need ongoing research into techniques for health promotion and prevention initiatives, coupled with education and practical training for the stakeholders into what they can do, why they should be doing it, and how to do it with the resources likely to be at their disposal. They must be trained in understanding community health needs and how to develop co.nmunity support

for new ideas and solutions. They must also learn the value of evaluation of outcomes so resources can shift to changing priorities of needs as required to obtain desired outcomes.

Dr. Trevor Hancock of Toronto is recognized as a leader in the development of the concept of healthy communities in Canada. In a speech in Montreal in October of 1990, during the **Canadian Healthy Community Projects Conference**, he stressed the need to be creative, flexible and imaginative if we wished to see real change.

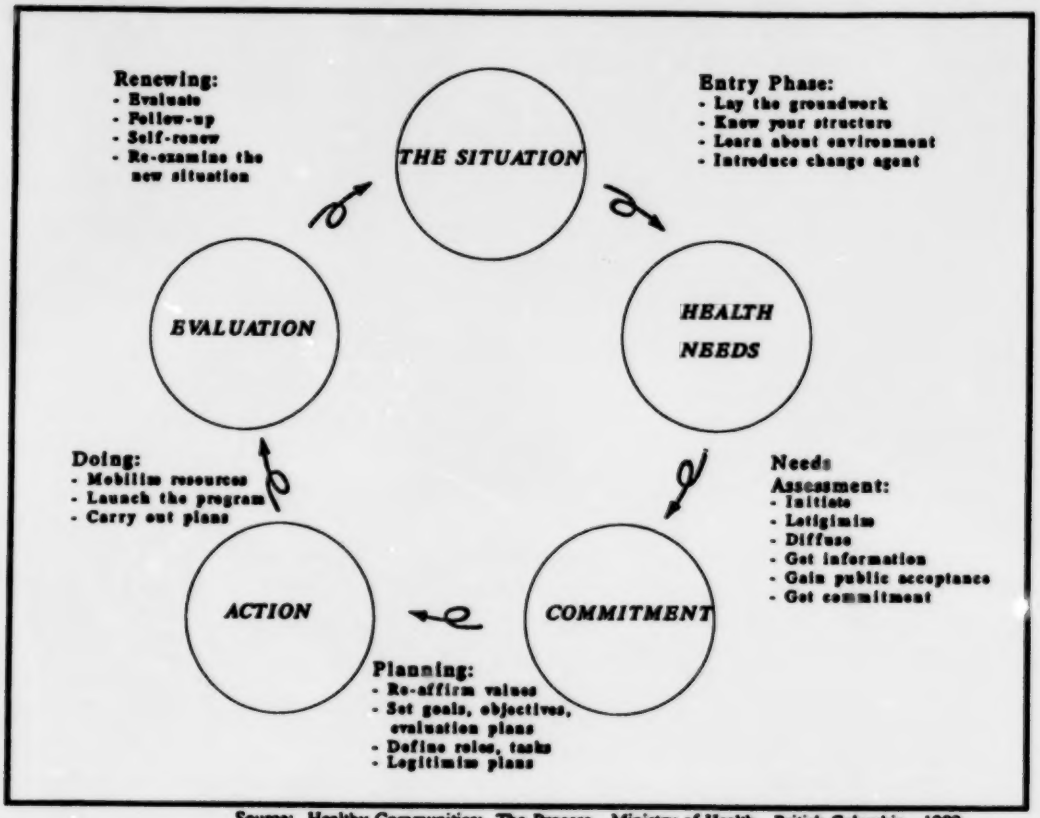
People from a variety of sectors have to be involved, with the traditional health sector giving some ground to others. Using the following diagram, he illustrated his comments on integrating concepts of viability, equity and sustainability with health, environment and the economy if we wished to achieve a healthy system:



Dr. Hancock suggested that we must be **"thinking globally and acting locally"** if we wished to be successful. He felt that local communities have more opportunity to create change and build coalitions with more allowance for innovative activities compared to other levels of government. Municipalities were closer to the people and thus more responsive. Perhaps we can look at the sources of ill health instead of only medically treating the results.

At times, this community approach to health issues means that we will come up against real power and we must be prepared to defend our health over profit and property rights. We must be able to take the long-term view for the collective protection and best interests of our citizens and of our communities.

The following model is taken from a guidebook on **Healthy Communities: The Process**, produced by the Ministry of Health in British Columbia. This overview of the process illustrates the need for ongoing evaluation and action in the dynamic situation of trying to respond to community health needs.



Source: Healthy Communities: The Process. Ministry of Health, British Columbia. 1989.

We will return to this concept in our section on recommendations.

V. Current Government Activities in New Brunswick to Address *Health Promotion and Prevention Issues*

New Brunswick was the province which appointed the first Minister of Health in the British Empire in 1918. Over the decades since, our province has been making efforts to improve public health policy for the benefit of the citizens.

However, as the expectations of our citizens continued to increase and the reliance on the existing structure of services placed strains on our financial resources to meet those demands, the government has been taking steps to look at where we are and where we are going with health issues.

Since the implementation of the **Equal Opportunity Program in 1967**, the province has struggled with the effort to promote equitable access to health and community resources by combining varying degrees of local, regional and provincial control of decision making; service standards and delivery; and the funding of those services.

The **McKelvey Levesque Commission on Selected Health Care Programs** examined some components of the medical system but pointed out that other issues must be looked at as a package.

This important report has been recognized as a turning point by asking government to take a longer view in their planning process and attempt to integrate all government policy in effective strategies to protect and enhance the health status of our people for today and for tomorrow.

The **Premier's Council on Health Strategy** will work to develop a provincial strategy in conjunction with other stakeholders. Obviously the Department of Health and Community Services will have a large role to play in outlining and then implementing a strategic plan on health promotion and prevention initiatives. We are pleased that the **current proposed Corporate Plan of the Department of Health and Community Services** has developed **five major goals** that will link quite nicely with the overall government strategy to improve health status of New Brunswick citizens. **These five goals formally express the Department of Health and Community Services' intentions to**:

1. **Increase the number of years individual residents of New Brunswick live free of major illness, disability and handicap.**

2. **Increase emphasis on promotion of well-being and prevention of social dysfunctioning.**

3. **Assist individuals and families achieve and maintain well-being.**

4. **Promote the achievement and maintenance of a healthy physical and social environment.**

5. **Maintain or increase the accessibility, affordability and appropriateness of health and community services for the citizens of New Brunswick.**

We can see the impact of these general goals in other recent departmental reports such as the policy framework document **Playing for Keeps: Improving our Children's Quality of Life** developed by the **Office of Childhood Services** and **Enhancing Seniors' Independence: Building for the Future** which is the policy framework document produced by the **Office for Seniors**. We would also draw attention to the new policy framework for mental health services announced by the provinces in 1988.

The Health Promotion and Disease Prevention Unit and the rest of the Public Health and Medical Services Division should be working closely with the Planning and Evaluation Branch of the Department of Health and Community Services in encouraging more linkages among the interested parties for health promotion and prevention programs. For example, we should be seeing more support for the forms being undertaken by the **Mental Health Commission of New Brunswick**. Perhaps our Council could provide some advice in that regard.

Communication among government departments and agencies could definitely be improved, and everyone seems to pursue their programs in isolation from each other. Although most departments claimed to be doing ongoing evaluation of their services, they could not be specific about what evaluation had been done or supply documentation for it.

It did not appear that a mechanism was in place for regular communication or coordination of health promotion or prevention programs being undertaken by community groups. Many of these groups were receiving some level of provincial and/or federal government funding but their strategies were poorly integrated; i.e., public campaigns on drinking, heart education, smoking, drug use, etc.

If we are to make the most of volunteer and non-profit community resources, we must heighten the levels of mutual respect and cooperation between government and the community groups. Our Council has been encouraging input from these groups to involve them in policy development and decision making in a proactive, collaborative manner. We encourage the Department of Health and Community Services and other provincial departments to do the same.

This consultative strategy is very consistent with the current government's philosophy as evidenced by the creation of this Council and other events such as the **Premier's Round Table on the Environment and the Economy.**

We recognize the important epidemiological work undertaken to create the **"Health Status of New Brunswickers"** report and the **"New Brunswick Heart Health Survey Report".**

There is a **New Brunswick Heart Health Coordinating Committee** that is involved in the creation of the provincial Heart Health Program. There is also a **Working Committee on Cancer Control** headed by the provincial Cancer Society. Another example is the **Provincial Interdisciplinary Committee on Suicide Prevention.** These committees could serve as a model for inter-sectorial cooperation on particular problem and risk areas.

We also noted a strong level of communication between the provincial and federal government (especially Health and Welfare and the Centre for Disease Control) in sharing information. We did not see enough evidence of information sharing to the municipal level of government or a recognition of their possible role in strengthening community health aside from a few communities who have begun **Strengthening Community Health Projects** such as Bathurst and Sackville.

The **"Health Status Report"** seems to have generated focus on heart and cancer issues, yet the data also indicated that **car accidents are the second highest factor in potential years of life lost by both males and females for the period 1982-86 in New Brunswick. Suicide was the third highest factor for males in terms of potential years of life lost for that period.**

The leading causes of death for the period of 1981-85 in New Brunswick were:

1 - diseases of the circulatory system
2 - neoplasms (cancer)
3 - diseases of the respiratory system
4 - external causes of injury and poisoning.

Hospital utilization patterns also indicated injury and poisoning cases to have a higher rate of hospital separations than cancer cases for the year of 1984-85. Cuts to public health prevention services should be examined in light of these statistics.

Statistics published by the **Canadian Institute of Child Health** show that the **leading causes of death for children aged 5-14 in Canada in 1985 were:**

55% injuries
19% cancer
6% birth defects
5% nervous system
15% other causes.

The causes for hospitalization of children aged 5-14 in 1983 were led by respiratory illness (with the bulk of admissions in this category related to chronic diseases of tonsils and adenoids and asthma) followed by injuries. **Therefore, we must once again draw attention to the need to look at sub-groups in our population to identify trends for which actions may be required.**

We, therefore, would like to see a strategy to deal with injury and poisoning prevention in a more successful manner. For example, the reduction of head injuries, spinal cord injuries and other results of motor vehicle accidents and falls could well be important in reducing costs for medical and community support costs. According to the Canadian Paraplegic Association, for example, a typical spinal cord injured patient would spend 78 days at the rehabilitation centre in addition to their stay for acute services at the hospital. Perhaps we could convince insurance companies to be more proactive for prevention if they had to charge premiums for high-risk activities that reflected the real costs of a serious accident. In any case, we should begin to recognize the opportunities to reduce demands and costs for injury treatment by improving effective strategies for injury prevention.

In summary, we see the need for more consultation, more information sharing, and more coordination of current activities to lead to better evaluations and planning processes to achieve measurable outcomes in the future. We must not assume that this is taking place in a systematic fashion but rather should require the Department to outline in some detail how they will improve consultations and coordination and with whom. Such consultation must involve the front-line service providers such as doctors, nurses, social workers, advocate groups, and others who are dealing directly with the needs of people. **The process should always identify what is to be accomplished; how it will be done; who will be involved; when it will be completed; what resources will be required; and when and how it will be evaluated.**

We must ensure that available resources are used wisely and redirect resources where the outcome will be more measurable.

VI. Summary of the Provincial Government's Response to Health Promotion and Prevention Issues

The government of New Brunswick has had a long history of interest in public health issues. Local communities recognized the need to have some kind of provincial standards to deal with the prevention of epidemics of communicable diseases.

The Public Health Act of 1887 established a Provincial Board of Health in the province although it was a weak system. Reforms led to the creation of a Provincial Department of Health in 1918 with Dr. Williams Roberts appointed as the first Minister of Health in the British Empire.

Thus, one could argue that the government and people of New Brunswick have shown leadership in efforts to address preventable health problems and have supported a role for government involvement in the field of prevention.

Over the last decades, we have heard many expressions of the benefits to be obtained through promoting healthy lifestyles, protecting the environment and preventing unnecessary injuries or illness. Despite this acknowledgement of the positive results such as improved quality of life and possible savings to our expensive health care system, we wondered whether the provincial government has adequately delivered a coordinated and effective response to health promotion and prevention objectives.

We wanted to support more ongoing efforts to address health promotion and/or prevention concerns with the public at large or specific target audiences perceived to be at risk.

We collected information presented in the first draft of this report to outline the more apparent programs delivered by provincial government departments and agencies. We did not focus on departments who have plans to get involved with health issues but do not yet have programs in place. We should also mention here the obvious support in principle by all government departments to the objective of a healthier and happier population as expressed in the **Health 2000** policy statement from the Province in 1990.

The Council would like to encourage all government departments and agencies to recognize their role for developing and implementing healthy public policy and to give higher priority to efforts that could improve the health status of their clients and employees.

Using the broad definition for the determinants of health, we will need to see creative efforts in time of fiscal restraints to address such social problems as

poverty, family violence, literacy, self-esteem, education, employment, family break-ups, violence against women, adequate housing, substance abuse, teenage pregnancy, transportation, etc., if we want to see a true transformation of health status. This includes the need for effective allocation of financial and human resources geared to real outcomes for at-risk segments of our population.

We noted that few, if any, of these programs have been independently evaluated by a source outside of the department involved. Most of the evaluation of effectiveness was a subjective appraisal provided by the person or branch who delivered the program or service. We were also surprised to see that few of these programs had specific objectives or targets that could be measured to determine effectiveness of the initiative.

We noted that a number of pilot projects and small special programs that seemed to start up and end without real evaluation were based on federal project funds that did not provide for continuity of projects once established.

Most of the provincial programs were "on demand" to be delivered on request to schools and community groups. There seemed to be little planning as to "who" received "what" resources "when". The same approaches and resources were often used year after year.

However, this is not to diminish the obvious support and interest in government to public health and safety concerns. With more coordination, planning and evaluation, perhaps more could be accomplished with what we have as resources now. It may also be necessary to increase the investment into health promotion and prevention as the best strategy to control unnecessary growth to other systems that treat health and social problems allowed to develop to the acute or crisis stage.

We have decided in this version of the report not to go into detail about all of the individual initiatives offered by all of the provincial departments and agencies. We have this material available on request. We would, however, like to draw attention to some of our general observations on the Department of Health and Community Services and on the Mental Health Commission of New Brunswick.

Department of Health and Community Services

From the very name of this Department, one can rightly assume that initiatives to support public health status would be supported and actively encouraged. The public health services of this province have enjoyed a reputation in the past for the high visibility and community involvement of the public health nurses and other professionals working in the Department.

Following reorganization of the provincial government delivery and management structures through the Office of Government Reform and other internal processes, there are some suggestions of confusion in the health promotion and prevention services. Staff roles and access to resources have changed to some extent, and links between sections of the Department have blurred.

The amalgamation of health and social services personnel has taken place in name but perhaps not in fact. The larger, combined mandate of this super Department has obviously created some problems in grappling with a larger, more complicated budgeting, management, and communications structure.

In the many interviews conducted to date with Department officials at all levels, it was evident that a good deal of useful data and information has been developed or is in the process of being developed by various sections and sources within this Department. However, it was also clear that there is not an effective and comprehensive system for sharing all of the appropriate information with all of the interested parties in and out of the Department.

The current "library" in the Department should be improved and kept up to date with regional access to the basic list of holdings which should be separated into public and internal/confidential sections. The Council office has developed a basic catalogue system for our library which we make available to those who are interested. The research materials from our Council will be turned over to the Department at the end of our mandate, but we would like to see their information sharing process reformed.

We would now like to discuss the Department's ongoing programs for health promotion and prevention.

Health Promotion and Disease Prevention (HPDP) Unit

This Unit comes under the **Public Health and Medical Services Division**. Headed by a Director who is also the Provincial Epidemiologist, the Unit also has Consultants with responsibilities to support program areas such as AIDS, Reproductive Health, Nutrition, Immunization, Disease Control, Smoking, etc.

We noted that the **Public Health and Medical Services Division** has been reorganized. The **Medical Consultant and Support Unit** includes medical consultants and rehabilitation consultants. The **Community and Environmental Health Unit** and a unit for the **Chief Public Health Officer** and **District Medical Health Officers** is in this Division.

It seems that units were divided up to make them roughly equal in staff size, but perhaps not designed to fully integrate program planning and delivery related to health promotion and prevention in particular.

Communications are possibly fragmented and inconsistent within these units and become even more of a problem when dealing with the full Department or other Departments and non-government agencies involved in health promotion.

We would like to commend the production of two significant reports from the Department of Health and Community Services with some financial support from Health and Welfare Canada. The report titled **"Health Status of New Brunswickers"** released in 1990 provides a useful snapshot of the types of health problems in the province. It will now be possible to set targets for reducing rates of incidence of certain problems and measuring whether strategies aimed at health promotion and prevention are successful.

The same can be said of the **"New Brunswick Heart Health Survey Report"** released in December 1989. It clearly demonstrated the scope of the problem and the lack of knowledge among many of our population of the risk factors that may lead to heart disease.

The Department has already begun to address heart health issues with federal funding for public education campaigns and other initiatives to be developed under this strategy with a 5-year plan of action. A committee has been formed of 22 representatives of government, industry, voluntary agencies, and professional associations to work on this strategy. (As of February 21, 1991, the committee had met once with another meeting being planned for March.) Heart disease is to become a top priority, with emphasis on different intervention modalities for smoking, nutrition, exercise, etc.

The **"Heart Health Survey"** will be redone in the fourth year of the strategy to measure results.

"AIDS Education Strategy" is underway with more emphasis on youth education. Negotiations were underway to determine the level of department funding to AIDS-NB for the provincial telephone information service. District Medical Health Officers and local public health services are to take an active role in public education. A media campaign has begun with further activities to come, such as workshops through the community colleges. They are trying to link with the Occupational Health and Safety Commission and employer and employee groups in implementing a work place strategy on AIDS.

"Cancer 2000 Committee" is composed of groups trying to address issues related to prevention and control of cancer.

Hospital Services

Hospitals are beginning to use their captive audience of patients to receive health education while in hospital for treatment and attending out-patient clinics. Hospitals are using their facilities for community groups and others to offer public lectures, displays and hand-out literature on matters related to health promotion and prevention.

Medical Health Officers

The province has had an ongoing problem in recruiting and retaining doctors to serve in these positions. Some of this problem is attributed to the fragmentation of policy development and implementation structures. The provincial *Health Act* may require major reforms to reflect current realities of the health system and objectives to be attained. For example, the powers of public health inspectors could be enhanced and the penalty levels increased to serve as more effective deterrents.

Recruitment and salary levels of inspectors remain a large problem, especially with lack of training facilities for francophone inspectors. Perhaps the development of technicians would improve the problem.

Eighty percent of inspectors' time during spring, summer and fall deals with septic disposal system inspections, and restaurant inspections are very limited. It was suggested that current strategies for the reporting of communicable diseases are not effective. The level of reporting is probably quite low for New Brunswick. We would like to see the issues of confidentiality and the logistics improved for reporting all types of sexually-transmitted diseases.

Even the problem of proper cause of death on some death certificates could be questioned if we are trying to get accurate statistics on such problems as suicide.

New Brunswick can be proud of its policy on enforcement of immunization of children prior to entering the public system. However, it was agreed that public health should be addressed more consistently throughout the school system, including keeping track of immunization records.

Public Health can offer pre-natal services, including home visits for mothers who have socio-economic problems or for subsequent births where risk factors are suspected.

Screening tests for hearing, vision and speech problems should be done at an early age.

Rehabilitation Consultants

We met with the three rehabilitation consultants from the Public Health and Medical Services Branch. They reminded us that rehabilitation services are not just provided in this province to treat current health and disability problems, but the goal is to restore levels of function to normal ranges, to improve the level of function as much as possible, and to prevent or reduce future loss of functions.

A **"Master Plan on Rehabilitation Services"** for the province is expected shortly.

The Office for Childhood Services

The Office was to provide a forum to coordinate government policy development and program planning for childhood services for all Departments, including the Department of Health and Community Services.

Our Council had active contact with the Office for Childhood Services and they provided a focus point for groups or individuals with suggestions on the effectiveness of current programs and/or ideas for reforms.

An Interdepartmental Committee and a Provincial Advisory Committee were established to assist the Office in its work. The Office released a major document to serve as a **"Policy Framework for Children's Services in New Brunswick"**. We encourage everyone to review this important document.

Office for Seniors

This Office is lodged within the Department of Health and Community Services which was established in December of 1989. The Office provides a forum for the coordination of government policy and program development for seniors across all departments.

A Provincial Advisory Committee of non-government groups has been formed, along with an Interdepartmental Committee.

The Office has already produced a useful **directory of services available to seniors in New Brunswick.** A **"Policy Framework"** has been submitted to Cabinet, along with an action plan calling for certain things to happen by 1992-93. We are reviewing these documents.

The Office for Seniors has an active interest in health status and health programs for senior citizens. They have also prepared a study of long-term care for frail elderly persons. We will continue links with the Office as our mandate proceeds.

Alcoholism and Drug Dependency Commission

The Province announced in November 1991 that the Department of Health and Community Services will be absorbing responsibility for the Alcoholism and Drug Dependency Commission. We have been told that this will not reduce the previous levels of treatment services and the efforts at public education programs.

Mental Health Commission of New Brunswick

Along with meeting with senior administration officials from the Commission, we were provided with copies of the **"Manual for Board Members - New Brunswick Mental Health Commission"** completed in April 1990. This binder provides a comprehensive outline of past, current and proposed directions for mental health services in this province.

As the Commission is relatively new and is developing within a time of severe fiscal restraints, we will have to monitor the outcomes achieved over the next two years in the area of prevention and promotion of healthy lifestyles.

These program changes are also to be accomplished within the new administrative structures established by the Commission with far greater involvement in regional decision making and consumer participation.

Special problems have been identified with the needs of children, adolescents and senior citizens. The issue of suicide prevention will be a high priority.

The NB Research Institute on Mental Health is being developed as a vehicle to offer more independent sources of information on mental health issues.

Provincial Mental Health Policy

In the 1988 fall legislature, the government announced its intention to adopt a new policy framework for mental health services, which called for:

- The development of a balanced network of institutional and community-based mental health services.
- A network of services and supports designed to meet the needs of the individual on a regional basis, to the extent possible.
- All community-based options to be explored before recommending that an individual be admitted to hospital.

- The need to allocate sufficient resources to the mental health system and, in particular, to the development of community-based services.

- The development and strengthening of informal support groups for the mentally ill, such as friends, families, neighbours and self-help groups.

- An increased emphasis on activities aimed at preventing mental illnesses and increasing the number of qualified service providers.

- The proclamation of amendments to the Mental Health Act to meet the requirements of the Charter of Rights and finally,

- The introduction of a ten-year plan of reallocation of resources from the institutional level to the community sector.

Mission

The mission of the Mental Health Commission of New Brunswick is to improve, restore and/or maintain the mental health and emotional well-being of the citizens.

This will be accomplished through providing programs for:

- prevention
- treatment
- rehabilitation
- maintenance, and
- promotion

which are:

- focused on the individual,
- effective in their outcome;
- accountable in terms of the management of human and fiscal resources and
- apt to ensure individual and community involvement.

Principles

The Mental Health Commission believes that:

People must have access to a range and variety of services that adequately meet their particular needs, regardless of who they are and where they live.

Services must be planned with the individual requiring them, his/her family members and significant others. Services must encourage the individual to take part in community life, promote self-determination and ensure respect for individual differences.

The service system must provide for continuity of care through efficient coordination mechanisms at the individual and system levels. A collaborative approach between community organizations, professionals and users of services is essential to this coordination.

Services must be distributed equitably throughout the province, particularly attending to rural/urban disparities. All levels of services must be equally available, from prevention programs to highly specialized services.

The responsibility for mental health services must be shared by the regions and the communities. This will ensure that services are flexible and designed to meet the particular needs of the residents of each health region.

Volunteer organizations and self-help groups have a vital role to play in the mental health network and must receive the support they need from governmental organizations in order to be able to fulfil this role.

Each part of the system must be accountable for the quality of the services it provides, as well as for the responsible use of its human and material resources.

Services must be focused on the individual with the ultimate goal of his/her community reintegration. They must be provided in the least restrictive, most natural setting possible and contribute to a positive image for mental health.

Services should be designed to meet individual needs with particular attention to services for groups such as children, teenagers, the elderly and persons with serious mental disorders who receive minimal or no services adapted to their particular needs.

A balance must be struck between the rights and concerns of users, families, mental health workers and the public.

VII. Some Examples of Innovative Approaches

During the course of our research, we came across a number of interesting projects that seemed to be cost-effective and very participatory in nature in their attempts to address some of the health-related issues we were reviewing.

We have not intended to describe every successful project that came to our attention nor to rank them in order of priority. We would be happy to refer any inquiries to our information sources for more details on these initiatives.

New Brunswick Projects

a) Partners in Development

This project was promoted by the Habitation New Brunswick (HNB) group (formerly known as the Provincial Committee of Affordable Housing Coalitions in New Brunswick) with the active support of the Canadian Council on Social Development (CCSD) as a means to enable New Brunswick communities to be more successful in responding to socio-economic problems. Existing resources could be better utilized to stimulate and support growth and developments, especially in these times of fiscal restraint.

> *"The mission of the Partners in Development is to improve the living standards of the disadvantaged, including improved housing conditions, better educational attainment, reduced levels of dependency, reduced social problems, enhanced health, improved self-confidence, and a higher capacity for self-help and mutual aid."*

The organizational structure calls for a provincial management committee, local development committees, local government officials committees, and a project animator. The structure and plan provide for liaison among the various committees and with provincial and federal government officials. Their Action Plan has three phases: Planning and Negotiation; Demonstration and Refinement; and Progressive Implementation. Two communities are already involved in this pilot project (Chipman and Pigeon Hill - Côteau Road) and several others are expected to be signed up shortly.

b) Screening and Counselling Clinics Operated by the Faculty of Nursing through Senior Nursing Students at the University of New Brunswick

This screening clinic for adults has been operated at the university since 1980 and some evaluation of the results indicate that this service has been successful in changing lifestyles to reduce health risk factors and to help identify health conditions for the client.

Some staff members from the Premier's Council on Health Strategy were personally invited to take part in the clinic which involves three visits over a nine-week cycle. A senior nursing student conducts the interviews and screening tests with a Nursing faculty member present in the adjoining room. Risk factors were identified using the Health Hazard Appraisal (HHA) questionnaire which uses computer analysis to compare the risk factors of the participant with nationally-accepted standards. Personal and family health history, height and weight, blood pressure, fit kit, haemoglobin, urinalysis, vision and hearing tests were conducted.

The nursing student used every opportunity to do non-threatening counselling by explaining test procedures and purposes and by discussing the results with possibilities for corrective action. The nursing students at that university are trained in matters related to health promotion. Client problems were categorized using the Omaha Problem Classification System using one or more of the four domains of environmental, psychosocial, physiological or behavioral.

We were given access to a published report from a faculty member showing a 1-3 year follow-up study. Results indicated clients had a 70% success rate in either correcting or somewhat correcting problems identified in their initial screening process.

This concept of using nurses and/or senior nursing students to conduct screening clinics and counselling sessions may have a great deal of potential. It could also be combined with the community health clinic concept to both strengthen health promotion and prevention emphasis while using personnel who could be salaried. This process would reduce time spent unnecessarily with a physician who would be billing on a per-visit basis instead of a time-spent basis.

c) Back in Action Program

This program was designed and established to address a serious chronic problem in New Brunswick workplaces. The loss of trained and experienced workers and the economic burden of 25 million dollars (Workers' Compensation Board) as a result of back, neck and shoulder injuries is truly unacceptable.

The Back in Action Program has been developed and is being implemented through the Occupational Health Section of the New Brunswick Occupational

Health and Safety Commission (NBOHSC) with financial support from the Workers' Compensation Board (WCB). A Back in Action Steering Committee with representatives from the labour, management and medical communities as well as the NBOHSC and WCB resource persons was established to oversee the implementation of this program.

The program is built on the concepts that it is ongoing in nature, there is full participation from the workforce, and everyone must know and understand their place of work. Also, the principles which guide the program are structured in a manner which is flexible enough to personalize the program to fit the needs of any particular workplace.

In a relatively short time, the Back in Action Program has been making measurable headway towards achievement of the program's goal and objectives. Interest and support for the program is evidenced by the results indicated by company participants and the favourable comments received. Based on the positive results to date, they strongly recommend that the Back in Action Program be continued with regular outcome evaluations reviewed to lead to wider implementation across the province.

They have shown that it is possible to provide cooperative training and leadership at the workplace to reduce the incidence of musculoskeletal injuries and the problems they create. The cooperative approach fostered in this program is beneficial to employers, management and employees. It can also reduce costs for health care, injury and insurance systems. Back in Action can make everyone a winner!

d) Single Entry Point Pilot Project

The pilot projects for this program have been led by the Department of Health and Community Services in the Acadian Peninsula and Fredericton area. A formal evaluation was prepared for the Minister of Health and Community Services and we expect that report to be released to the public once it has been fully reviewed by the Department.

Our Council has had access to that information and note some obvious results. Nursing home waiting lists have been significantly shortened, collaboration among community agencies has been working reasonably well and people are accessing community services as an alternative to institutional placement.

Some further input will need to be considered from the stakeholders as to whether this project could be expanded to the full province. Tighter controls on the assessment should help limit the services provided to a priority of real needs. We need to know if community support services could be stretched further to respond to larger numbers of program participants. How do we ensure equitable services in communities that do not have an infrastructure of services already in place?

Changing the eligibility criteria for admission to a nursing home may reduce waiting lists, but will also increase the level of care required for those who are admitted. Can we enhance the availability of public health nurses to work with seniors in their homes to foster self-help and independent living skills for seniors who may not be covered by the Extra-Mural Hospital nursing services?

How do we balance the responsibilities of family support versus outside intervention? Should a family member have to give up their own job to stay at home with an aging parent who has chronic health needs?

We must not over serve the frail elderly person but we should provide adequate interventions to prevent the more costly premature placement in a hospital bed or nursing home bed. We look forward to the Department's strategy for follow-up on the Single Entry Point Pilot Project.

e) Student Assistance Program - Fredericton High School

The Student Assistance Program at FHS is a joint venture involving the school, its students and staff, parents and the community at large. (Bathurst schools have also successfully piloted a similar program.)

In recognition of the need to address the problem of alcohol and drug abuse among students at the Fredericton High School, project funding was obtained from health and Welfare Canada through the Community Action Program of the National Drug Strategy.

The program was put in place at this large high school in March of 1990 and has proven extremely effective. The project funding runs out at the end of March 1992, and efforts are underway now to secure permanent funding.

f) Active Living 2000

The Canadian Summit on Fitness held in June 1986 described the vision of the fitness movement:

> *"The vision of fitness by the year 2000 depicts a society that values well being as fundamental and an integral part of day-to-day life. Canadian social structures, the family, the schools, the workplace, the health-care system, will all enthusiastically embrace and reward daily physical activity and behaviours which contribute significantly to health and well being. Regular physical activity and optimal well being will be ingrained as important and widely accepted values in Canadian society (in effect, a Canadian 'cultural trademark')."*

The former provincial Department of Tourism, Recreation and Heritage (now the Department of Municipalities, Culture and Housing) submitted a paper to the Council to advocate that the concept of *Active Living* be used as a major vehicle for the promotion of health. *Active Living* is a lifestyle theme which has received the endorsement of the federal and provincial Ministers of Recreation. Their document is supported by research studies emphasizing physical activity as the cornerstone of a healthy lifestyle with particular focus on the prevention of coronary heart disease.

For example, studies reviewed by the Centre for Disease Control in Atlanta, Georgia, has shown that physical inactivity is as strong a risk factor for coronary heart disease as high blood pressure, high serum cholesterol and cigarette smoking. There is evidence that increasing levels of physical activity in the population at large may have more effect on lowering levels of coronary heart disease than would modifying any one of the other three risk factors.

As a beginning step to promote the *Active Living* concept, the Department has already submitted to the Council a draft action plan for the "Focus on Active Living: 1992 Project." Copies of this action plan have been circulated to the Council members for reaction. We are awaiting word of the plans for follow-up on *Active Living*.

Out-of-Province Examples

g) Community Health Centres

The Council has reviewed a report entitled Co-Op/Consumer Sponsored Health Care Delivery Effectiveness released in June of 1990 by Douglas Angus and Pran Manga. This report reviews a number of models for community access to health-related services that could be offered in a cost-effective manner without reducing quality of care or access to more specialized services when required.

The report examines 10 different styles of community programs using American and Canadian models, some of which have been in existence for a period of years. This has provided data to measure cost of service delivery and consumer participation and satisfaction.

Studies have indicated that community health centres can significantly affect utilization patterns and reduce costs by significantly reducing hospital utilization, prescription drug and other over servicing of the patient.

Effective grouping of other tertiary services at the community health centre such as family planning, social services, health promotion, etc., means that clients can do one-stop shopping, and immediate follow-up is more likely. Such intervention at earlier stages may prevent more acute problems from developing later.

Budgeting for such community health centres is much easier to predict with capped salaries for physicians and other staff. It also allows for team problem solving on the site using skills from other non-physician professionals as appropriate.

This process could offer some remedy to meet the needs of smaller communities, in particular. There is also a role for the consumers and community leaders to perform in selecting priorities for tertiary services and keeping the services accountable. These centres seem more effective at health promotion, early intervention and reduction of negative health outcomes through their screening and health-education services in addition to diagnosis and treatment services.

Perhaps the province should explore this approach in a pilot project program. Our Council has prepared some further material on the topic of community health centres and it is available on request.

h) Canadian Healthy Communities Project

This is a national project jointly sponsored by the Federation of Canadian Municipalities, the Canadian Institute of Planners and the Canadian Public Health Association, with funding provided by the Department of Health and Welfare. (Note that this program should not be confused with the Strengthening Community Health Project Partners sponsored by the NB/PEI Branch of the Canadian Public Health Association. They are currently talking of merging with the more widely implemented Canadian Healthy Communities Project.)

This is a network of communities across Canada in which the municipality has officially passed a resolution to create a cooperative local approach to foster an environment that supports "health" for its citizens. Everyone, from politicians, municipal staff, local business, the private sector and the individual residents, will work in partnership to achieve their goals. Social, economic and environment issues are addressed in relation to good health. Information sharing and planning resource guides are provided to the communities involved with coordination of this exchange through a national office in Ottawa.

New Brunswick should encourage this model for consideration by more of our municipalities.

i) Health Innovation Fund

This program is administered by the Premier's Council on Health, Well-Being and Social Justice (formerly the Premier's Council on Health Strategy) in Ontario.

The Health Innovation Fund was launched in August of 1987. Its main component is a Health Strategies Program designed to support innovative projects in health. The Fund was originally allocated $100 million to administer over a

4-year period ending March 31, 1993. (This works out to a per capita allocation of $10.44 based on the 1989 population figures for Ontario.) Of this amount, $70 million was allocated to the Health Strategies component of the Fund.

The other 3 components of the Health Innovation Fund included an Ontario Health Survey and a Mental Health Survey; Hospital-in-the-Home Pilot Projects; and a program for the development of Comprehensive Health Organizations together with a commitment to double enrolment in Community Health Centres and Health Service Organizations.

The primary emphasis of the Fund is to encourage and support projects that are local and community-based and sponsored by non-profit organizations. It is not meant to provide financing for capital construction or high technology diagnostic equipment (including its testing). Feasibility studies, as well as education projects exclusively focused on video and theatre productions, have also been declared ineligible by the Fund.

j) Injury Awareness and Prevention Centre - Alberta

This centre advocates injury awareness and prevention by stressing that many injuries are predictable and preventable. We should not allow ourselves to think of "accidents" which imply that we have no control over the event. The accident may still happen, but we can prevent or reduce the consequences in many cases. Many injuries are caused by human behaviour and decisions. Certain groups are at higher risk for injuries. We continue to see emphasis on treatment of injuries with minimal resources directed at prevention.

The centre has produced public awareness resource materials, a newsletter, research on injury costs and prevention programs, national conferences, etc.

> *"A death from injury is the tip of an iceberg; for every fatal injury, 45 require hospitalization, about 1300 result in a visit to an emergency department, and an unknown number a visit to a physician or clinic."*
>
> - Louis Hugo Francescutti, Ph.D., M.D.

The Alberta Centre is participating in an effort to establish "Injury Control Objectives for Canada for the Year 2000." There may be value in this province getting involved with that initiative and developing an understanding of the Centre's other work.

We were particularly impressed by the **"Heroes"** program directed at preventing injuries among youth from high-risk activities undertaken without proper regard for safety equipment and safety practices. This campaign has been extremely well received.

k) The Acti-Menu Health Program

This program is operated by the Provigo supermarket chain in Quebec to educate the public on how to make good decisions for healthy weight, physical fitness and a desirable level of blood cholesterol. They have recognized that diet is an important factor in the prevention of chronic health problems. Their materials were developed with the support of scientific approaches to health promotion and consultation with a good variety of specialists.

The resource materials developed and the strategy for this campaign deserves further follow-up. Perhaps the materials could be utilized with permission in this province as they are available in both French- and English-language versions.

The campaign includes a healthy menu program for hotel restaurants, risk factor screening to consumers in the store, product labelling for healthy content factors, and information leaflets for the public. A study was to be carried out by the nutrition department at the Université de Montréal to verify whether participants actually make diet changes as a result of this campaign.

l) Other

The Council has accumulated a variety of material on other existing innovative projects from both in and out of province. We shall continue to collect such information for sharing with other interested partners in New Brunswick.

VIII. Need for Evaluation

The concept of evaluation must be ingrained into all efforts to improve health status of our citizens. Program designers and service providers should not fear a process of evaluation being built into their project or program that allows one to determine if the outcomes achieved have been within the targets set for that initiative.

If one is expected to measure in some way the outcomes achieved, it is very important to plan carefully as to the objectives and specific targets being sought. This will also assist in developing a strategic action plan that identifies the stakeholders, the target group(s), roles, resources required, and a time line for expected outcomes. If expected outcomes are not being achieved, emphasis can shift to new strategies that will be cost-effective and within the available pool of resources.

The evaluation process itself must be determined so the necessary data can be collected in a format that allows meaningful evaluation to take place at specified points in time. The evaluation process should not be more cumbersome and expensive than the type of initiative being undertaken calls for. Stakeholders involved in the program should also be involved in evaluation, although larger projects may require independent outcome audits to rationalize continued allocation of resources.

We can look to other sectors, such as business and science, to examine research techniques and assessment models found to be effective in measuring outcomes without collecting data and information that is wasteful.

The timetable for evaluation should depend on the size of the program, the scope of objectives being sought and the amount of resources involved. Some projects may require regular quarterly results, annual analysis or even several years or longer before results could be measured in a meaningful way.

We would suggest that all new projects related to health promotion and prevention not receive funding or resources for implementation until an evaluation process has been developed as part of the operational plan that includes realistic targets.

Current health promotion and prevention programs, in government especially but also for community groups receiving government funding, should be directed to create such targets and evaluation plans beginning in the next fiscal year after this report is presented to government.

IX. Specific Issues for Targeted Health Promotion and Prevention-Related Activities

Note: These subject areas are not necessarily listed in order of priority but were selected on the basis of potential effect on controlling health and social services cost escalation for the future. Many of these subject areas are inter-related and public campaigns to reduce one problem could be tied to reductions of other health problems.

a) **Heart Health**
b) **Cancer Control**
c) **Injury Prevention**
d) **AIDS (and other sexually-transmitted diseases such as chlamydia)**
e) **Mental Health**
f) **Family Violence**
g) **Exercise**
h) **Anti-Smoking Strategy**
i) **Suicide Prevention**
j) **Spinal Cord Injuries**
k) **Head Injury Reduction**
l) **Responsible Alcohol Use Awareness**
m) **Nutrition**

We will explore current levels of health promotion and prevention programs in these areas, and identify innovative suggestions for responding to these problems.

We would like to do some cost/benefit analysis to predict how we could reallocate or save dollars from acute care for prevention activities. This will require more data on typical costs for persons who require treatment and/or services due to these health problems.

Please refer to Appendix III for some Health Status Related Information which may help to point out the urgency of these problems.

X. Recommendations

General Recommendations:

1. The Province must make a formal public statement that they will use planning mechanisms in future to ensure that government programs, legislation, economic policy, social policy and other government reforms will include a recognition of their commitment to healthy public policy. The government must lead by example.

2. The Province must develop clearly defined, measurable, population health goals, with targets and strategies for obtaining results in partnership with consumers and service providers. Organizations and department programs requesting funding for new projects related to health promotion and prevention objectives should not receive provincial government resources until an operational plan has been developed that includes setting specific targets, timetables, and an appropriate process for evaluation. Existing projects and programs should be advised to begin to create the same type of operational plan if they wish to seek renewal of funding from the Province starting for the 1992-1993 budget year.

3. The government of New Brunswick should continue to seek information from other jurisdictions on projects and strategies that have been proven effective in improving the health status of the public at large or to effectively respond to health problems of specific target populations. The methodology of communication may be different for different target groups.

4. Priority directions should be set out for the future development and enhancement of health promotion and illness prevention initiatives with an identification of a designated percentage of government budget funds to be assigned for health promotion and prevention initiatives.

5. Community involvement in policy issues and programs should be strengthened.

6. The health promotion infrastructure at the provincial and local levels should be strengthened through greater collaboration by Government, New Brunswick hospitals, nursing homes, the voluntary and professional sectors and other key stakeholders.

Public School System Recommendations:

7. There should be a formal consultation process between the anglophone and francophone sections of the Department of Education to allow for more consistency in the content and approaches used to deliver health education in the public school system. ("Curriculum without a delivery is useless as is a delivery without a curriculum.")

8. The Home and School Associations, schools, and other interested parties could develop an ongoing campaign to ensure that school children of all ages have access to a healthy breakfast and lunch each school day in a manner that will not create a stigma for those receiving assistance.

9. Greater emphasis should be placed on self-esteem at all grade levels to reduce substance abuse and suicides. This could be done by giving opportunities for success through a range of extra-curricular activities. Teachers should recognize and give extra focus to students at risk with reasonable access to other professional supports in cases which warrant such intervention.

10. Holistic health education must be promoted as an essential component of the school curriculum and school environment and not as a matter to be responded to after all the other matters have been dealt with in terms of setting minimum requirements and allocating resources.

11. The Department of Education should develop a smoking policy for schools and encourage its implementation at the district level which would reinforce the anti-smoking message.

12. Health education curriculum should be part of the required core curriculum at all grade levels, from kindergarten to Grade 12. The subject of nutrition and good healthy eating practices and good mental health should be highlighted in the school curriculum at all grade levels by being integrated in other subjects such as science and home economics.

13. Formal links should be made at the provincial level among the Department of Education, the Department of Health and Community Services, the Mental Health Commission, and the many provincial groups interested in health education. Curriculum content, school visits and special programs, media campaigns, and other health initiatives should be more closely coordinated for maximum effectiveness and consistency.

14. Current health-related curriculum could be enhanced to include more emphasis on stress control techniques, response to tragic events, home care of common health problems such as colds or fevers, recognition of real costs to using Medicare services, personal responsibility for one's health status, awareness of family violence, focus on concept of promoting wellness versus reliance on health system to treat illness and other issues of practical value to the students in their future lives.

15. Instruction time and curriculum content in both anglophone and francophone school districts should approach as near as possible the guidelines recommended by the Canadian Association for Health, Physical Education and Recreation (CAHPER) at all grade levels from kindergarten to Grade 12.

16. The various school districts and the Department of Education have access to a good range of resource materials and curriculum guides. However, we note a tremendous range of material and courses currently being used and unused in our system. We would request that the Department of Education establish minimum standards for health education curriculum to be used in all schools in the province.

17. It is our understanding that current academic training programs for teachers in the Atlantic universities do not offer much in terms of course content related to health education and social problems such as family violence, divorce, etc. When we consider the knowledge and tact required to impart health curriculum to students, it seems to be a gap in their education. We recommend that the universities be advised to develop a mandatory course with health education content to prepare for a possible future licensing requirement for teachers to obtain their licence in New Brunswick (i.e., similar to the course *Santé scolaire 1310* at l'Université de Moncton for students enroled in elementary school education).

18. The Department of Education, in conjunction with the school districts, should improve in-service training opportunities for teachers involved with health education. We could make greater use of such trained personnel as home economists.

19. The introduction of the kindergarten program is making assumptions about parental roles and support. We feel that a kindergarten lunch program is of considerable importance and further consideration should be given to this matter. Some parents cannot afford to pay for lunches; other parents are working and could not volunteer at lunch time; and we have not seen any aspect of the plans made to date to offer consistent supports from district to district. This issue of lunches and snacks should be specifically addressed in the planning process.

20. The Family Living course (or Développement humain in francophone districts) should be a required course to be offered during at least one grade level in senior high school for all students prior to graduation.

21. Physical education should be a required course for all grades with an emphasis on "carry over" skills.

22. Students and teachers should have at least one opportunity in each school day for being involved in some kind of physical exercise.

23. The Department of Education and the Department of Health and Community Services, in conjunction with local school boards and students' councils and after consultation with dieticians or home economists, should move immediately to develop detailed operational plans for a healthy food policy for schools to cover cafeteria, on site sale of snacks, and fund-raising activities (i.e., selling candy).

24. Information should be made available for parents and students on how to choose good content for school lunches and snacks, including nutrition and value for money. This could be done by the home and school associations, for example, in conjunction with dieticians, home economists and social workers.

25. Each school district should create an active board committee to develop greater awareness and emphasis on health promotion and prevention issues. Teachers should be actively involved in this initiative. Membership on this committee would be open to non-board members.

26. Every school should have an active occupational health and safety program to benefit staff and students.

27. The role of the public health nurses must be supported in the school system by allocating them an adequate amount of time to fulfil their duties. This would allow for early screening of health problems and appropriate counselling and interventions for students while at school (e.g., addressing teen pregnancy).

28. Student Assistance Programs with adequately trained staff modeled on the Fredericton High School project should be supported by the Department of Education on a trial basis for other larger high schools in New Brunswick.

29. Training should be more readily available to parents on such issues as communication, budgeting, discipline, nutrition, etc., to create a stronger home environment. This could be done through home and school associations and community colleges and should include access to resource persons such as teachers, home economists, social workers and public health nurses.

30. Students' Councils, and other peer groups in the school system such as TADD, should be encouraged to take a positive role in student education programs on substance abuse (i.e., Safe Grad programs, assemblies with celebrity speakers, public announcements at school and at special events on reminders/tips for personal health and safety).

31. Driver education programs at the school are a useful investment in creating more safety-conscious drivers. Fees should continue to be charged to students to reflect their savings on future insurance costs to underwrite the expenses in offering the courses.

32. The Human Growth and Development course should be available in all junior high schools across the province, with the continued involvement of parents in allowing their children to follow all or part of the program (applies to anglophone sector only as this course seems to be adequately available in the francophone districts).

33. Peer counselling groups could be supported to allow students to get involved in linking students with problems to assistance before a full crisis is reached. Some high schools already have such programs in New Brunswick.

34. In the future, the assignment of teaching staff to courses involving health education should include consideration of that teacher's training, experience and motivation to effectively teach the material to the students.

35. By using newsletters of the NB Teachers' Federation, professional development days and other means, teachers should be actively targeted with information to encourage them to improve personal lifestyles and knowledge of health matters to be able to serve as better role models for their students.

36. Consideration should be given to developing a credit course that would allow students to provide direct service to public health and social service projects in their own community.

Specific Health Issues to be Addressed:

37. The Province should establish specific targets and strategies to reduce the current rates for (as discussed in the "Injury 2000 Objectives Report"):

- family violence
- motor vehicle accidents
- head injuries
- spinal cord injuries
- suicide
- poisonings
- fire injuries/fatalities
- back injuries
- hip fractures with seniors.

38. The Department of Municipalities, Culture and Housing should be supported in their plan to coordinate a provincial emphasis on the *active living* concept to increase physical activity and fitness levels of all sectors of our population.

39. It is recommended that the Minister of Health and Community Services recommend to his colleagues, the federal-provincial Ministers of Health, that they support the development of a new national standard on the legal age to buy tobacco, to be embodied in new or updated federal legislation.

40. It is recommended that the Minister of Health and Community Services repeal the provincial Act Respecting the Use of Tobacco by Minors to end the confusion surrounding the legal age to buy tobacco in New Brunswick.

41. It is recommended that the Minister of Health and Community Services develop and bring forward a Tobacco and Health Act embodying, at a minimum, the following actions:

1) an addiction warning required to be placed on all packages of tobacco sold in New Brunswick;
2) a leaflet containing detailed health warnings required to be placed in or on all tobacco packages sold in New Brunswick;
3) detailed health warnings required to be placed on the front door or window and also near the tobacco display in all retail outlets selling tobacco;
4) a ban on sales of packages containing fewer than 20 cigarettes:
5) a ban on cigarette vending machines;
6) a ban on the advertising of tobacco products in New Brunswick, with time lines corresponding to the current federal ban;
7) a license process for retailers to allow for enforcement.

42. It is recommended that the Minister of Finance, in cooperation with the Minister of Health and Community Services, incorporate an education program about tobacco legislation into the New Vendors Education Program.

43. It is recommended that the New Brunswick Government, in order to protect nonsmokers from second-hand smoke, enact legislation which would allow smoking in enclosed public places only where such smoking takes place in designated smoking areas with adequate ventilation.

44. It is recommended that the New Brunswick Government require employers to develop policies on smoking for their workplaces, said policies to be designed to protect nonsmoking workers from the effects of second-hand smoke. A recognition program to reward employers for the establishment of non-smoking policies should be created.

45. It is recommended that the Minister of Health and Community Services consider requests for funding from the NB Interagency Council on Smoking and Health to promote nonsmoking activities and coordination (requests to be considered in context of guidelines set up by the Department of Health and Community Services) with a special priority to stop more youth from starting to smoke.

46. The Province should aggressively pursue an integrated strategy to market healthy food products which could be linked to New Brunswick grown farm products, the fishing industry, grocery store participation and a healthy menu program for restaurants.

47. "Community Health Centres" should be pursued as an alternative delivery system that could include screening services, counselling and information programs, and other services at one location in addition to ambulatory medical care. This could be a partial replacement role for smaller community hospitals.

48. Standards for the safe handling of food should be improved with increased emphasis on monitoring compliance in facilities serving/handling food products for consumption by the public with training for food service personnel should be more available and some basic information should be included as a job requirement.

49. Injury awareness and prevention efforts should be given a higher priority. We support additional efforts and resources for the NB Occupational Health and Safety Commission to improve safety records at the worksite which would benefit employers and employees.

50. We encourage groups such as the NB Safety Council to strengthen partnerships with other community resources to promote safety concepts to the public on traffic matters, family violence, bicycle helmets, seat belt enforcement, motorized recreational vehicles, diving, poisoning, and other such opportunities to reduce injuries especially directed to youth and younger adults.

51. The AIDS Strategy of the government should give greater emphasis to the financial support of AIDS-NB with clear guidelines as to which functions of service they should perform to avoid duplication by government staff.

52. A broad campaign to increase the number of smoke detectors in residences in New Brunswick could include changes to the building code to cover existing residences and new construction, insurance companies getting involved with premium discounts, banks and mortgage companies requesting smoke detectors as part of mortgage requirements, and continuation of municipal fire departments and the Fire Marshal's Office in promoting smoke detectors.

53. Drunk driver legislation and penalties should be aggressively promoted and enforced to serve as a clear deterrent. We should be working towards a goal of reducing allowable blood alcohol counts for drivers to lower levels.

54. Legislated procedures should be in place to require reporting of drivers posing a risk to safety of themselves and others. This could be more than requiring physicians to report medical problems. This could be designed to allow anyone to contact the Motor Vehicle office and a mandatory re-test could be required after the driver reports in for an interview in person. This would allow the examiner to decide if a re-test was warranted.

55. The Province could consider developing models of incentives for good healthy practices such as an annual day off for employees who do not have sick time in the previous year, worksite smoking cessation programs, lunch-time exercise programs, etc.

56. The Mental Health Commission should be given additional resources to support community programs and prevention efforts directed at such problems as suicide and/or the need for hospitalization for other mental health problems as well as the promotion of other mental health programs.

57. Nutrition education and food supplement programs could be developed for delivery by public health nurses and/or through community health centres to specific target groups such as teen mothers-to-be, school children from poor families, senior citizens, families on social assistance, etc. A special food supplement/counselling effort, for example, could be addressed to expectant mothers from low-income groups to reverse statistics of low birth weights and corresponding high risk of health problems.

58. Private employers and other large employers should be encouraged to develop effective Employee Assistance Programs to help reduce problems of employees before they reach the crisis stage and to encourage good health initiatives for employees at the worksite.

59. The target age group for preschool screening by public health nurses was children between 5 and 6 years of age (prior to entry into Grade 1). With the implementation of the new kindergarten program, the target group has been changed to focus on children between 4 and 5 years. Screening any children new to the province and entering elementary school also continues to be necessary. Even earlier screening for babies with possible risk factors should be available from birth on.

60. We support the need for additional dietician professionals to be added to the public health network who could also be available for public and school education projects.

61. The public, and especially low-income groups, should be encouraged to understand the value of gardens as a partial source of cheaper quality food to supplement their resources. Courses on home gardening should be offered in each area of the province with the assistance of the Department of Agriculture and the community colleges. Other courses focusing on life skills could be offered through home economists and social workers employed by the Department of Health and Community Services.

62. We think consideration should be given to combining the management of the Health Promotion and Disease Prevention Unit with the Community and Environmental Health Unit of the Department of Health and Community Services to improve their coordinated approach to public health concerns.

63. We encourage support for the Heart Health Strategy concept and would like to see the plan developed and released to the public to include what role is required for government and what role for the NB Heart and Stroke Foundation, Positive Heart Living, and other stakeholders. We noted interest in a provincial cardiac rehabilitation program.

64. We would like to see the Cancer Strategy developed and released to the public which clearly identifies the role of the Cancer Society and that of government in such areas as public education, breast self-examination, regulations for tanning parlours, smoking, diet and a host of other cancer prevention initiatives.

65. Research should be gathered on the subject of office buildings with closed heating and air circulation systems and possible effects on employee health.

66. We have reviewed the Policy Framework for Children's Services and the Policy Framework for Services to Seniors now that they have been released to see if they will sufficiently address the health promotion and prevention needs of these groups. We ask the Department of Health and Community Services to respond to the health promotion issues in these reports.

Communication/Information Sharing:

67. The Department of Health and Community Services should take a lead role in developing an improved library and information system to gather materials/data related to health promotion and prevention. Access to non-confidential items should be available to non-department stakeholders and/or researchers. A computerized catalogue of existing programs of government and non-government groups involved in health promotion and prevention could be maintained to encourage effective use of resources and identify patterns of duplication or gaps in the system. Information to front-line staff has to be timely and they should be more involved in developing service priorities. Consideration for information for illiterate persons must be addressed. Bilingual resources should be available where appropriate.

    If the Department is unable to carry out this function, then funding should be provided to another source to do this; i.e., university library, hospital library, NB Safety Council, etc., or some combination of outlets.

68. In establishing provincial and regional program priorities, consideration should be given to cultural differences which might also exist. These factors can sometimes affect the pertinence of the established priority for a particular region or community. Communities can be on different footings when it comes to their readiness to initiate pilot or innovative approaches to programs. (Different levels of support took place for family planning curriculum implementation and for integration in public schools.) Those who show the desire to initiate new programs or approaches should be encouraged.

69. Because of the importance of ensuring equal participation for the province's two official language communities in the development and implementation of policies and programs, all written material circulated through provincial and regional offices, in particular those targeted for comment or discussion, should be available in both French and English at the same time to all appropriate personnel.

70. There has been a problem in the availability of French-language health promotion materials. Formal arrangements should be made within the Department of Health and Community Services and the Department of Education to ensure that adequate and current educational resources such as videos, brochures, films, slides, posters, etc., are available in both languages to teachers, public health nurses and others involved in health promotion and education.

71. The Department of Health and Community Services must strengthen interdepartmental and interagency cooperation and coordination of efforts on health promotion and prevention. Some tasks could be more clearly divided for leadership such as current campaigns related to alcohol and drug education.

72. Hospitals, nursing homes, special care homes, etc., should be encouraged to give a higher profile to their efforts to deliver and support health promotion education for patients, staff and the community (i.e., Resident Care Plans, employee assistance, Back in Action Program, etc.).

73. Greater efforts should be given to avoid creating new resource materials with similar content to existing material and use that new production funding to increase volume of distribution of existing resources (i.e., fancy videos and posters may have limited circulation due to high production costs).

74. The Department of Health and Community Services should investigate the feasibility of a health information line such as developed in Quebec to help advise consumers if they need to seek medical services and/or to give general health information to the public on an automated telephone service. Models have been developed by CNIB in Montreal, the Nova Scotia Hospital, and other Canadian locations.

Miscellaneous:

75. Government could assist community groups in health promotion efforts by offering access to government professional personnel, meeting space at schools and community colleges if needed, part-time staff secondments, etc. We should not be caught up in the idea that dollars alone will solve the problems.

76. Community needs assessments should be used to develop local strategic plans to health issues based on local concerns and demographic factors with responses that are appropriate, accessible, acceptable and affordable.

77. The Department of Health and Community Services should investigate immediately the possible criteria necessary to establish a Health Innovation Fund that could provide special funding for demonstration projects and/or creative research to improve health status and/or prevent injuries, etc.

78. We would like to see some leadership by the province in encouraging local communities to adopt strategies such as the Canadian Healthy Communities Project and the Partners in Development Project.

79. In addition to the current health education role of physicians, we should look to other sources of health counselling such as rotating adult screening clinics done in communities by nurses, peer counselling by seniors in their local clubs, more home visits to expectant mothers by public health nurses, and community health centres and the greater use of other health professionals such as chiropractors, nurses, home economists, occupational therapists, physiotherapists, etc.

80. The Council supports the concept of self-help/mutual aid groups that function with minimal financial support, if any, from government. It may be worthwhile to designate a provincial coordinator to stimulate the creation of more of these peer-based groups which could help ease unnecessary use of professional resources and acute-care facilities.

81. We would like to see improved access to genetic counselling so that potential parents at risk can make informed choices about family planning matters.

82. We must see a clear policy statement by government and medical professional associations that guarantees persons with disabilities full access to medical care without discrimination such as withholding treatment due to perceptions about the quality of life for a person with a permanent disability.

83. We would recommend that the Department of Health and Community Services establish a formal consultation with various health professional associations to review greater opportunities for these professionals to be involved in efforts to improve the health status of our population. Some groups that come immediately to mind, based on our meetings and literature search, would include physicians, chiropractors, nurses, occupational therapists, home economists, social workers, and dieticians.

84. We recommend that the Department of Health and Community Services release the master plan for rehabilitation services to allow public input on how the system will try to respond to the rehabilitation needs of persons with temporary or chronic disabilities.

85. We encourage the Province to pursue a comprehensive policy in all areas of their responsibilities that will ensure that our environment is sustained to protect healthy air, water and soil for this and future generations. We refer to the work carried out by the **Premier's Round Table on the Environment and the Economy**.

86. We urge the provincial government to undertake a healthy balance of public policy priorities between the opportunities for economic development and the necessary protection for the health status of our citizens.

XI. Conclusion

From the literature review and other research conducted to date by the Council staff, we believe strongly that the topic of Health Promotion and Prevention must be an important focus for the government and other stakeholders to pursue.

If we truly wish to improve the quality of life to be enjoyed by all of our citizens at all age levels, we must encourage government to demonstrate concrete leadership for a coordinated plan to address health promotion and prevention issues.

We recognize the difficult economic realities faced by governments at all levels and understand that our recommendations have to be considered in the light of many competing priorities.

As government struggles to reconcile conflicting demands and expectations with the available financial resources, we are hopeful that the concept of health promotion and prevention will remain a priority and an active response to these recommendations will be implemented as resources from other program savings are realized.

We would repeat the need to set aside a specific percentage of government budget funds each year to move forward on this agenda. Some of these actions are not costly and may be possible with existing structures. Some require legislative or administrative decisions to give authority to existing momentums.

To be successful, there must be support and involvement of the stakeholders from all sectors to mobilize individual and community commitment to the proposed targets. Perhaps the positive side of fiscal restraints in government is a realization that government alone cannot do the job. However, government must be prepared to allocate resources to the campaign and do more than announce support in principle.

Consultation with the stakeholders as to where cuts can be made in the current programs to shift some of the savings to more effective strategies will give them an incentive to get on board with the fiscal reforms. Partnerships are very much preferred to unilateral decisions.

If we invest wisely in health promotion and prevention objectives, we can surely hope to reduce the growth of health care and social costs while improving quality of life for more people for longer periods.

Appendix I

General Summary of Survey "Prevention and Promotion of Healthy Lifestyles - Questions for Community Groups"

(Appendix to "**An ounce of prevention...** Position paper on **health promotion and prevention issues**")

Prepared by the
PREMIER'S COUNCIL ON HEALTH STRATEGY
565 Priestman Street
Fredericton, New Brunswick
E3B 5X8

PREVENTION AND PROMOTION OF HEALTHY LIFESTYLES
QUESTIONS FOR COMMUNITY GROUPS

Name of organization: _____

Address: _____

_____

_____ Postal Code: _____

Contact person: _____ Telephone: _____

1. List activities/special projects related to prevention and/or promotion of healthy lifestyles (include reference to target audience, number of persons reached each year, estimate of annual budget costs, and whether delivered by staff persons and/or volunteers).

_____

_____

_____

_____

_____

_____

_____

2. What types of resource material do you have available? (i.e., films, posters, pamphlets, speakers)

_____

_____

_____

_____

QUESTIONS FOR COMMUNITY GROUPS

3. Does your group operate fully in both French and English in all of your education programs?

_____

4. What portion of New Brunswick do you operate in? _____

_____

5. How do you evaluate the effectiveness of your prevention and/or healthy lifestyle programs?

_____

_____

_____

_____

6. Does your group receive funding and/or resource material for your programs on prevention and/or promotion of healthy lifestyles on a regular basis from:

	Funding support	Resource materials
a) Municipal government	Yes ___ No ___	Yes ___ No ___
b) Provincial government	Yes ___ No ___	Yes ___ No ___
c) Federal government	Yes ___ No ___	Yes ___ No ___
d) National affiliate	Yes ___ No ___	Yes ___ No ___
e) Foundations	Yes ___ No ___	Yes ___ No ___

f) Other (please identify) _____

_____

QUESTIONS FOR COMMUNITY GROUPS

7. Please indicate the level of importance you would attach to the following statements:

	Extremely Important	Quite Impt.	Impt.	Less Impt.	Not Impt.	
a) Increase use of seatbelts	___	___	___	___	___	(a
b) Reduce drinking/driving	___	___	___	___	___	(b
c) Pass legislation to restrict smoking in public places	___	___	___	___	___	(c
d) Improve public awareness about sexually transmitted diseases	___	___	___	___	___	(d
e) Address issue of suicide among youth	___	___	___	___	___	(e
f) Increase emphasis on knowledge of proper nutrition	___	___	___	___	___	(f
g) Regular physical exercise	___	___	___	___	___	(g
h) Workplace safety	___	___	___	___	___	(h
i) Retesting of drivers based on report of impaired sensory/motor skills	___	___	___	___	___	(i
j) Promote healthy hearts	___	___	___	___	___	(j
k) Encourage positive mental health	___	___	___	___	___	(k
l) Improve highway safety	___	___	___	___	___	(l
m) Injury prevention campaigns	___	___	___	___	___	(m
n) Early screening programs to identify health problems	___	___	___	___	___	(n
o) Improvements to community support programs	___	___	___	___	___	(o
p) Increase funding to prevention projects	___	___	___	___	___	(p
q) Give greater support to public health services	___	___	___	___	___	(q
r) Address issue of family poverty	___	___	___	___	___	(r
s) Focus attention on environmental concerns	___	___	___	___	___	(s
t) Enhance the role of schools in prevention	___	___	___	___	___	(t
u) Research to determine most effective ways to change behaviour/lifestyle	___	___	___	___	___	(u
v) Develop community health clinics	___	___	___	___	___	(v
w) Advertise community resources more effectively	___	___	___	___	___	(w
x) Encourage municipalities to promote healthy communities	___	___	___	___	___	(x
y) Use mass media more effectively	___	___	___	___	___	(y

QUESTIONS FOR COMMUNITY GROUPS

8. Do you have recommendations/suggestions on how to improve the outcome of prevention/promotion of healthy lifestyle initiatives?

9. What role do you see for the provincial government in the area of prevention and/or promotion of healthy lifestyles?

10. Are there any programs/projects you would like to offer but cannot, due to restrictions/limitations? Please specify:

QUESTIONS FOR COMMUNITY GROUPS

11. Please list any new programs/projects you anticipate delivering in the future:

_____

_____

_____

_____

_____

12. Other comments:

_____

_____

_____

_____

_____

Date survey completed: _____ By: _____

Please return this survey to:

Nancy Légaré
Project Officer
Premier's Council on Health Strategy
565 Priestman Street, Suite 304
Fredericton, NB E3B 5X8

or fax it to us at: 457-4899

THANK YOU!

The following is a summary of the responses to each of the survey questions.

Question #1

Most activities/special projects related to prevention and/or promotion of healthy lifestyles listed were delivered by volunteers. The target audience mostly included:

- the general public
- health professionals
- members of the organization/group
- government departments
- specific age groups.

Larger organizations with larger budgets were obviously generally able to offer more programs and services than the smaller ones with less funding.

The activities and special projects mentioned focused on:

- education and information programs/public awareness
- conferences/seminars/workshops/courses
- training and development programs
- rehabilitation and support services
- self help and counselling programs
- special events/fund-raising
- promotion of healthy lifestyles
- prevention of injury/illness/disease
- assessment/referral for care and services
- interpreters services.

Question #2

The most common resource materials mentioned were pamphlets or brochures. Most groups have speakers and videos/films available. Almost half answered having books/booklets available. A few answered having resource/teaching manuals and/or posters. Some have access to national library systems. Other documents and audio-visual materials were mentioned.

Question #3

The majority of groups either fully operate in both French and English in all their education programs or operate in English only, but provide informational materials in both English and French. A few of the organizations operate solely or predominantly in English. One group mentioned that USA-produced films and videos are available in English only. Another group mentioned an increasing number of written materials in minority languages.

Question #4

Most groups operate in all of New Brunswick. Other groups answered that they operate from their main office, but services are available virtually throughout the province through community branches or chapters and other support groups. A small number of groups indicated operating in certain areas only.

Question #5

Most of the groups do not evaluate the effectiveness of their prevention and/or healthy lifestyle programs, some assuming that the national office has reviewed the service and others relying on member or public feedback. Several mentioned not having the necessary financial/human resources to evaluate programs.

Question #6

Most groups receive **resource material** on a regular basis from a national affiliate. Almost half of the groups answered receiving resource material from provincial or federal governments. Few answered receiving resource material from foundations or municipal governments. Only one group answered receiving resource material from the municipal government.

About half of groups receive **funding support** for programs on prevention and/or promotion of healthy lifestyles on a regular basis from the provincial government. No groups answered receiving funding support from a municipal government. Only a small number receive funding support from federal government, a national affiliate and/or foundations.

Most groups rely on fund-raising, bequests and donations from other groups, service clubs, associations or foundations. Some mentioned receiving occasional support for certain programs from provincial and federal governments or other groups.

Question #7

NOTE: Not all statements a-y of question #7 were rated by every respondent, the results were therefore affected. Most questionnaires were completed by the most senior staff person or by a volunteer. Responses may reflect subjective opinions of the person who completed the questionnaire, although several mentioned trying to give the view of their organization as much as possible.

A general review of the answers to this question indicated that organizations/groups felt that the "extremely important" issues were:

a) Increase use of seat belts
b) Reduce drinking/driving
d) Improve public awareness about sexually-transmitted diseases
j) Promote healthy hearts
p) Increase funding to prevention projects
q) Give greater support to public health services
r) Address issue of family poverty
s) Focus attention on environmental concerns
t) Enhance the role of schools in prevention
u) Research to determine most effective ways to change behaviour/lifestyle.

NOTE: The above are only examples of the predominant responses given and are not listed in order of priority.

Question #8

The following are examples of recommendations/suggestions on how to improve the outcome of prevention/promotion of healthy lifestyle initiatives. They are not necessarily listed in order of priority, but simply illustrate the variety of answers given:

- Dedicated funding to prevention and promotion of healthy lifestyles
- Increase public awareness/ensure access of information to all citizens
- Target younger people and better utilize school systems to promote healthy lifestyles
- More extensive follow-up of services and of effective behaviour change
- Improved education and training to health professionals
- Base planning on a holistic view
- Evaluate needs and conduct research into motivation for change
- More concerted and coordinated effort by various groups
- More work with industry/workplace to help foster healthy lifestyles.

Question #9

The answers given for the role seen for the provincial government in the area of prevention and/or promotion of healthy lifestyles focused on four main areas: funding, coordination, education, and evaluation.

Question #10

Most groups mentioned that restrictions/limitations which prevented them from offering programs/projects were due to lack of resources and/or funding. The following are examples of some restrictions/limitations mentioned:

- Need for more consistent and direct contact with communities to motivate participation
- Resources and funding needed for groups focused on returning individuals to community from institutions
- Need for a toll-free info-line
- Need funding to guarantee bilingual services (not always enough funds for translation or service provision in both languages)
- Do not have adequate resources to do effective behavioral change targeted programming
- Lack of funding (provincially) for sign language interpretation
- Need for education, particularly to the primary caregivers and awareness to the general public
- Need for appropriate legislation put in place by government (ex.: Municipal tobacco restriction policies and enforcement of other applicable laws)
- Need for further coordination between government departments and organizations.

Question #11

The following are examples of new programs/projects that the groups anticipate delivering in the future:

- Increase services and resource information
- Research/Evaluation
- Increase public awareness of healthy lifestyle issues
- Education/Training
- Self help programs/Support groups
- Recreation workshops
- Provide palliative care
- Children's programs
- Youth houses.

Question #12

The following are examples of other comments:

- Importance of health programs being accessible to all New Brunswick citizens
- Importance of linkage between government departments to ensure needs are met and to ensure no duplication of services occurs
- Need for increased government funding and support to community groups
- Need for a healthy public policy to empower society to assume responsibility for its health
- Increase awareness of school districts as to what foods are served to students
- Include housing, income, leisure, work, etc., in definition of lifestyle
- Need for emphasis on "preventive" measures rather than "treatment" orientation of medical system.

Conclusion

The results of this summary as well as the completed questionnaires will be retained for possible further use by the Council during work on prevention and promotion of healthy lifestyle issues. The Council would like to thank the respondents who took the time to complete the questionnaire.

Appendix II

Departments, Groups and Individuals who Participated in the Information Gathering for this Report

(Appendix to **"An ounce of prevention...** Position paper on **health promotion and prevention issues")**

Prepared by the
PREMIER'S COUNCIL ON HEALTH STRATEGY
565 Priestman Street
Fredericton, New Brunswick
E3B 5X8

Submissions were received from:

- Ad Hoc Committee for Health Care Costs - Canadian Diabetes Association - NB Division
- Adhvaryu, Madhavi (Nursing student, UNB)
- AIDS New Brunswick
- Allen, Shelly (Nursing student, UNB)
- Alzheimer Society of New Brunswick
- Amyotrophic Lateral Sclerosis Society of New Brunswick Inc.
- Antle, Dr. G. M. (Family practice, Moncton)
- Armstrong, L. E. (Chiropractic patient, Hampton)
- Armstrong, R. B. (Chiropractic patient, Hampton)
- Arseneault, Anne-Marie (Faculty of Nursing, Université de Moncton)
- Arthritis Society - New Brunswick Division
- Association des conseillers scolaires du Nouveau-Brunswick
- Back in Action Program (New Brunswick Occupational Health and Safety Commission and Workers' Compensation Board)
- Barr, Gwen (Chiropractic patient, Hampton)
- Bedford, Vernon (Chiropractic patient, Grand Manan)
- Bolduc, Roland (Chiropractic patient, Saint John)
- Breau, Mary L. M. McKenna (UNB Faculty of Education)
- Brechhill, Joy (Chiropractic patient, Saint John)
- Brooks, Shelly (Nursing student, UNB)
- Burns, Stacy (Nursing student, UNB)
- Canada Games Aquatic Centre (Saint John)
- Canadian Cancer Society - New Brunswick Division
- Canadian Deaf-Blind and Rubella Association - New Brunswick Chapter
- Canadian Hemophilia Society - New Brunswick Chapter
- Canadian Mental Health Association - New Brunswick Division
- Canadian National Institute for the Blind - New Brunswick Division
- Canadian Paraplegic Association - New Brunswick Division
- Canadian Physiotherapy Association - New Brunswick Branch
- Canadian Red Cross Society - New Brunswick Division
- Canadian Rehabilitation Council for the Disabled - New Brunswick Branch
- Capital District Heart Support Group (Fredericton)
- Centre hospitalier Restigouche (Campbellton)
- Chiasson, Jennifer (Nursing student, UNB)
- Chiasson, Mary (Chiropractic patient, Saint John)
- Clark, Joan (Public health nurse, Chatham)
- Committee for the Identification/Intervention of At-Risk Families of Preschool-age Children (Fredericton)
- Connolly, Lane (Chiropractic patient, Saint John)
- Conrod, Dr. M. (Family practice, Moncton)
- Cook, Bernice (Chiropractic patient, Pennfield)

- Cooke, Cynthia (Nursing student, UNB)
- Day, Pauline (Chiropractic patient, Saint John)
- Denning, Kimberly (Nursing student, UNB)
- Department of Education - Francophone Curriculum Development Branch
- Department of Education - Provincial Office
- Department of the Environment
- Department of Health and Community Services (Bathurst)
- Department of Health and Community Services (Campbellton)
- Department of Health and Community Services (provincial office)
  - Alcoholism and Drug Dependency Commission
  - Occupational Health and Safety Commission
  - Office for Childhood Services
  - Office for Seniors
- Department of Income Assistance
- Department of Tourism, Recreation and Heritage (former provincial office)
- Department of Transportation - Provincial Office
- Donahue, Donald (School superintendent, Newcastle)
- Dr. V.A. Snow Centre Inc. (Hampton)
- Eatmon, Barbara Jane (Nursing student, UNB)
- École de nutrition et d'études familiales (Université de Moncton)
- Ellis, Sue (Saint John)
- Epilepsy New Brunswick
- Ericson, Penny (Faculty of Nursing, UNB)
- Farquharson-Lomax, Susan (Chiropractic patient, Lepreau)
- Fire Marshal's Office (former Department of Municipal Affairs)
- Forest Hill Rehabilitation Centre (O.T. Department, Fredericton)
- Fournier, M. Michel (Foyer Ste-Elisabeth Inc., Baker Brook)
- Fredericton YMCA-YWCA
- Gilbey, Valerie (Faculty of Nursing, UNB)
- Godin, Gabriel (High school principal, Bathurst)
- Goguen, Emery (School superintendent, Bathurst)
- Gordon, Ronnie (Chiropractic patient, Saint John)
- Goyeche, Dr. John (Psychologist, Fredericton)
- Grant, Teena (Nursing student, UNB)
- Hall, Barbara (Post Polio Syndrome, Saint John)
- Hansen, "Chip" Blae E. (Chiropractic patient, Westfield)
- Harris, Lauretta (Chiropractic patient, Saint John)
- Harrison, Wayne (Chiropractic patient, Saint John)
- Head Injury Association of New Brunswick Inc.
- Health Action Council (Saint John)
- Henderson, Dr. J. M. (Rheumatologist, Fredericton)
- Hickey, M. Suzanne (Chiropractic patient, Clifton Royal)
- Hooper, Cheryl (Chiropractic patient, St. Andrews)

- Human Development Council (Saint John)
- Jenkins, Pam (Chiropractic patient, Saint John)
- Jones, E. L. (Chiropractic patient, Saint John)
- Kelly, Dr. F. (Family practice, Moncton)
- Kelly, Glenn (Chiropractic patient, Hampton)
- Larlee, Darrell (Chiropractic patient, Campbellton)
- Lawless, Beverly (Faculty of Nursing, UNB)
- Leavitt, Ross (Chiropractic patient, Saint John)
- LeBlanc, Monique (Public health nurse, Bathurst)
- LeBlanc, Guy (Teacher, St-Antoine)
- Lee, Lana (Nursing student, UNB)
- Lee, L. Patrick (Chiropractic patient, Saint John)
- Legge, Jacqueline (Nursing student, UNB)
- Leonard, Joanne (Chiropractic patient, Saint John)
- Lions Clubs of District 41-0 and 41-N1
- Lomax, Donald M. (Chiropractic patient, Lepreau)
- Lynch, Christine (Nursing student, UNB)
- MacKenzie, Patricia (Chiropractic patient, Saint John)
- MacLean, Dr. Cathy (Family practice, Moncton)
- McAvine, Dr. T. (ECG Department, Miramichi Hospital, Newcastle)
- McCubbin, Jim (Chiropractic patient, Rothesay)
- McCubbin, Lorna (Chiropractic patient, Rothesay)
- McKelvey, E. Neil (Co-chair of the McKelvey-Levesque Commission, Saint John)
- Magee, Dr. Peter (Chiropractor, Saint John)
- Maker, Rodger (Chiropractic patient, Grand Manan)
- Malone, Walt (Chiropractic patient, Saint John)
- Marshall, Larry (Chiropractic patient, Saint John)
- Matchett, Lori (Nursing student, UNB)
- Mental Health Commission of New Brunswick
- Millett, G. D. (Chiropractic patient, Saint John)
- Moncton Hearing Impaired Council Inc.
- Monteith, Marion (Chiropractic patient, Westfield)
- Morgan, Dr. Leonard (Allergy - Family physician, Saint John)
- Morrell, J. Richard (Chiropractic patient, Aroostook)
- Morse, T. B. (Chiropractic patient, Grand Manan)
- Multiple Sclerosis Society of Canada - Atlantic Division
- Muscular Dystrophy Association of Canada - New Brunswick Provincial Office
- Neil Squire Foundation
- New Brunswick Advisory Council on the Status of Women
- New Brunswick Association for Community Living
- New Brunswick Association of Dieticians
- New Brunswick Association of Nursing Homes
- New Brunswick Association of Occupational Therapists

- New Brunswick Association of Speech-Language Pathologists and Audiologists
- New Brunswick Association of Social Workers
- New Brunswick Chiropractors Association
- New Brunswick Dental Society
- New Brunswick Extra-Mural Hospital
- New Brunswick Federation of Home and School Associations, Inc.
- New Brunswick Heart and Stroke Foundation
- New Brunswick Home Economics Association (provincial association)
- New Brunswick Home Economics Association (Fredericton Chapter)
- New Brunswick Hospital Association
- New Brunswick Housing Corporation
- New Brunswick Interagency Council on Smoking and Health
- New Brunswick Lung Association
- New Brunswick Medical Society
- New Brunswick Mental Health Nurses Group
- New Brunswick Nurse Educators
- New Brunswick Oncology Nurses Group
- New Brunswick Power
- New Brunswick Safety Council Inc.
- New Brunswick Senior Citizens' Federation Inc.
- New Brunswick Teachers' Association
- Noble, Leanne (Nursing student, UNB)
- Northorp, Dr. S. (Family practice, Moncton)
- Nova Scotia Council on Smoking and Health
- Nurses Association of New Brunswick
- Ouellette, Debra (Chiropractic patient, Saint John)
- Parkinson's Foundation of Canada - Fredericton Chapter
- Patrick, Dr. Allan (Urologist, Fredericton)
- Paterson, Elsa (Chiropractic patient, Saint John)
- Pelletier, Katia (Nursing student, UNB)
- Perry, Heidi (Nursing student, UNB)
- Pinfold, G. S. (Chiropractic patient, Saint John)
- Planned Parenthood New Brunswick Inc.
- Plant, Clarenda (Nursing student, UNB)
- Pollock, Lorraine (Home economist, Sussex)
- Popma, Dr. Harold T. (General practitioner, Sackville)
- Positive Heart Living Inc.
- Premier's Council on the Status of Disabled Persons
- PRIDE Saint John Inc.
- Public Health (Bathurst)
- Renault, Sister Cecile (Tracadie)
- Ring, Cindy (Nursing student, UNB)
- Robichaud, Paulette (Home economist, Tracadie)

- Robichaud, Valois (Professor, Shippagan)
- Sackville Community Health Committee
- Saint John Hearing Society
- Santé et réproduction (Bathurst)
- Senior Watch (Westfield)
- Single Parent Resource Centre (Saint John)
- Snow, Calvin H. (Chiropractic patient, Quispamsis)
- Sprague-Chestnut, B. (Chiropractic patient, Quispamsis)
- Tardif, Denise (Nurse representative, NB Interagency Council on Smoking and Health)
- The United Church Home for Senior Citizens Inc. (Sackville)
- Thompson, Holly (Nursing student, UNB)
- Thorne, Jane E. (Chiropractic patient, Saint John)
- Tracy, Elizabeth (Nackawic)
- Trudeau, Dr. Terrence (Psychiatrist, Moncton)
- Victorian Order of Nurses - Bathurst Branch
- Victorian Order of Nurses - New Brunswick Inc.
- Ward, A. Philip (Chiropractic patient, Saint John)
- White, Edwin (Chiropractic patient, Apohaqui)
- Wiggins, Nancy (Faculty of Nursing, UNB)
- Winchester, M. Ruth (Chiropractic patient, Saint John)
- Winters, Deanna (Nursing student, UNB)
- Wortman, Dr. Neil (School superintendent, Grand Falls)
- Youth Council of New Brunswick

Appendix III

Health Status Related Information

(Appendix to **"An ounce of prevention...** Position paper on **health promotion and prevention issues")**

Prepared by the
PREMIER'S COUNCIL ON HEALTH STRATEGY
565 Priestman Street
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CURRENT POPULATION STATISTICS
PROVINCE OF NEW BRUNSWICK

(Compiled from Statistics Canada Tables for June 1, 1989
Published February, 1990)

TOTAL POPULATION = 718,500 persons
Males = 354,100
Females = 364,400

By age groups: (male + female combined)

0 - 14 years	=	155,700
15 - 19 years	=	58,800
20 - 24 years	=	58,700
25 - 29 years	=	61,900
30 - 34 years	=	61,700
35 - 39 years	=	57,300
40 - 44 years	=	51,200
45 - 49 years	=	38,200
50 - 54 years	=	31,400
55 - 59 years	=	30,000
60 - 64 years	=	29,000
65 - 69 years	=	27,600
70 - 74 years	=	22,000
75 - 79 years	=	17,100
80 - 84 years	=	10,100
85 - 89 years	=	5,200
90+ years	=	2,700

SUMMARY

0 - 14 years	=	155,700
15 - 44 years	=	349,600
45 - 64 years	=	128,600
65+ years	=	84,600

MEDIUM AGE = 32 years

Statistics about Persons with Disabilities

Table #1: Canadian Population Figures on Persons with Disabilities

Geographical Region	Total Population	Persons with Disabilities	Percentage of Total
Nfld.	557 410	73 100	13.1
PEI	125 580	18 445	14.7
NS	864 140	145 715	16.9
NB	704 630	109 100	15.5
Que.	6 465 035	727 740	11.3
Ont.	9 058 595	1 263 220	13.9
Man.	1 022 255	160 865	15.7
Sask.	989 835	137 520	13.9
Alta.	2 345 415	279 425	11.9
BC	2 853 680	395 120	13.9
Yukon	23 180	2 045	8.8
NWT	51 530	4 570	8.9
CANADA	25 061 270	3 316 870	13.2

* Note that New Brunswick has the third highest disability rate in the provinces and territories of Canada and is significantly above the national average.

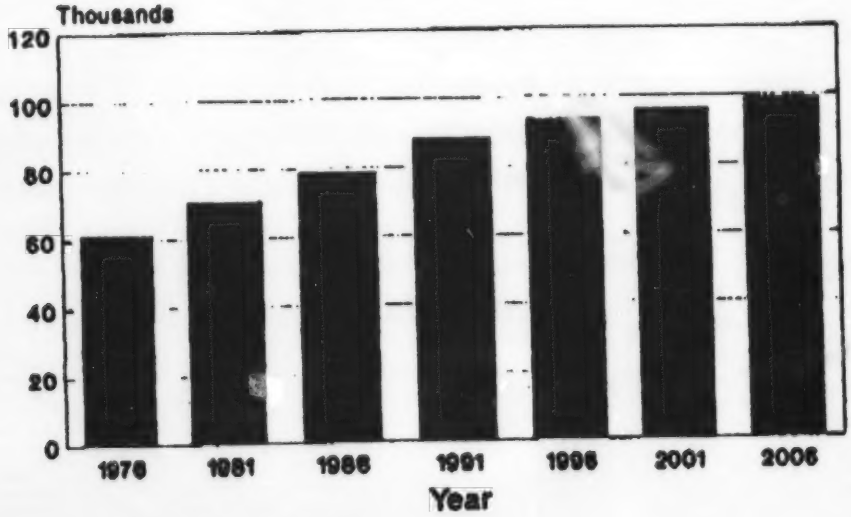
Table #2: Breakdown of Disabled Population Figures for New Brunswick by Age and Sex

Age Range	Male	Female	Total
0 - 14	6 410	3 495	9 905
15 - 24	2 380	2 985	5 370
25 - 34	4 450	4 340	8 790
35 - 44	5 750	6 030	11 780
45 - 54	5 580	6 250	11 830
55 - 64	11 090	10 195	21 285
65 - 74	10 045	10 570	20 615
75 - 84	5 785	8 300	14 085
85+	1 630	3 815	5 445
TOTALS	53 125	55 980	109 105

- **Projections**

The number of individuals age 65 and over also has been increasing and will continue to do so. From 81.1 thousand or 9% of New Brunswick's total population in 1976, the numbers are expected to increase by 2006 to 98.8 thousand or 13.1% of the total population. This represents a 62% increase over the 30 year period. However, the increase in the 65 and over population will not have reached its peak by 2006.

Population 65 Years and Over
New Brunswick 1976-2006



Sources: N.B. Statistics Agency 1989; 1990. Statistics Canada 1988, 91-518; 1987, 93-101.

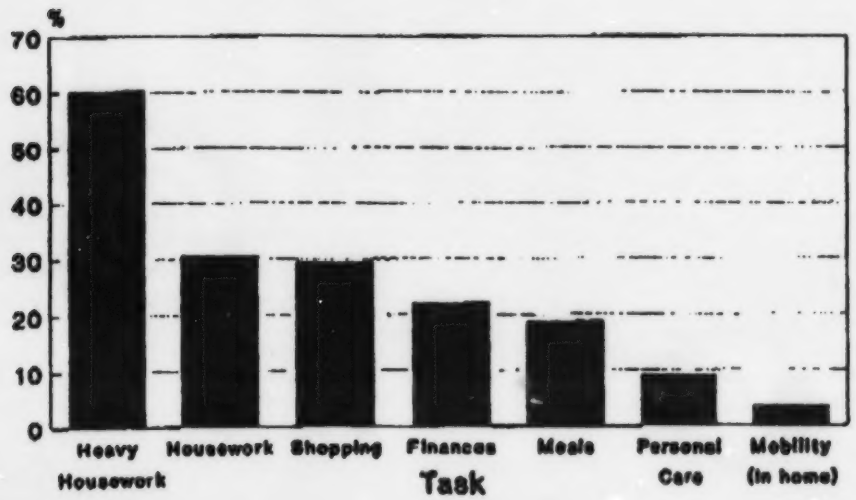
Source: "New Brunswick's Senior Citizens: A Socio-demographic Report." NB Office for Seniors. January 1992.

- **Dependency on Others (65+ Living in Private Households)**

It is not unexpected that individuals age 65 and over with a disability who live in private households would require assistance either with personal or household tasks. Assistance was greatest in the area of heavy household chores (60.2%). Approximately 30% received help with shopping and housework, and less than one-quarter obtained help with personal finances and preparation of meals. Fewer than one in ten obtained help with personal care and less than 4% received assistance in moving about the residence.

Just over 1200 individuals reported that they needed assistance with normal everyday housework but were not receiving any help.

Proportion of Individuals 65+ with a Disability who Require Assistance, New Brunswick, Private Households, 1986



Source:
Statistics Canada 1990, 82-602.

Source: "New Brunswick's Senior Citizens: A Socio-demographic Report." NB Office for Seniors. January 1992.

Income and Expenditures

Old Age Security (OAS)

The basic Old Age Security pension is payable to everyone who is 65 years of age or over and who meets the residence requirements. As of May 1991, 88,108 individuals in New Brunswick received either full or partial OAS pensions (Health and Welfare Canada, May 1991). Full basic OAS in May 1991 was $362.37 per month or $4348.44 per year (Health and Welfare Canada, 1991).

Partial OAS is based on the number of years an individual has lived in Canada and may range from 1 to 39/40ths of the full OAS. Of the small number of individuals who receive partial OAS, the majority receive their cheques outside Canada.

Number of Individuals Receiving OAS
New Brunswick, May, 1991

	Partial	Full	Total
Domestic	455	86,626	87,081
Foreign	792	235	1,027

Domestic - Persons receiving their OAS cheques in Canada.
Foreign - Persons receiving their OAS cheques outside Canada.

Source: Health and Welfare Canada, May 1991.

Source: "New Brunswick's Senior Citizens: A Socio-demographic Report." NB Office for Seniors. January 1992.

2.1 Demographic Data: Children and their Families

Children are becoming less numerous in New Brunswick and in Canada as a whole. Nationally, fertility rates have been below the established replacement rate of 2.1 since 1972.[2] In New Brunswick, the projections indicate that in relation to the total population, children aged birth to twelve will make up only 15.7% of the New Brunswick population in the year 2001, compared to 27.3% in 1971. (Chart 1)

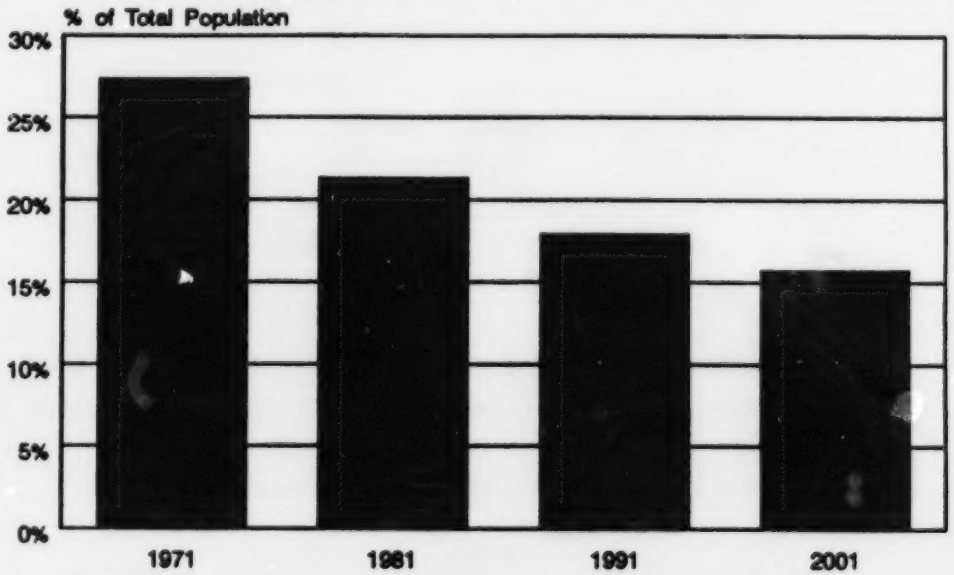
Chart 2 shows Statistics Canada estimates of the number of children in the age groups Birth to 4, 5 to 9, and 10 to 14. The fact that there are fewer children in the youngest age group points again to the falling birth rate.

Family size figures reflect the falling fertility rates. In 1961, the average number of children in a New Brunswick family was 2.3 compared to 1.3 in 1986.[3]

This trend has several important implications for future policy development. Fewer children today means fewer participants in the labour force tomorrow. Policies to strengthen the future labour force, both quantitatively and qualitatively, will be needed.

Chart 1

Children (Birth to 12) as a percent of Total Population, New Brunswick



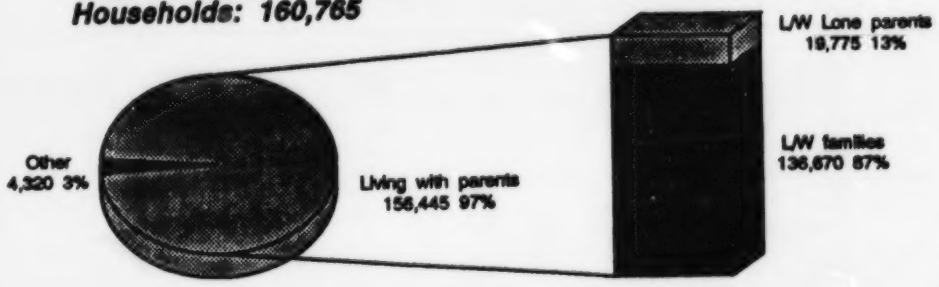
Source:

1. Statistics Canada, Census Data, 1971, 1981
2. N.B. Statistics Agency Projections, 1990

Source: "Playing for Keeps! Improving Our Children's Quality of Life." NB Office for Childhood Services. April 1991.

Chart 3

Percentage Distribution of Children under 15 Years in Private Households, by Living Arrangements, N.B. 1986

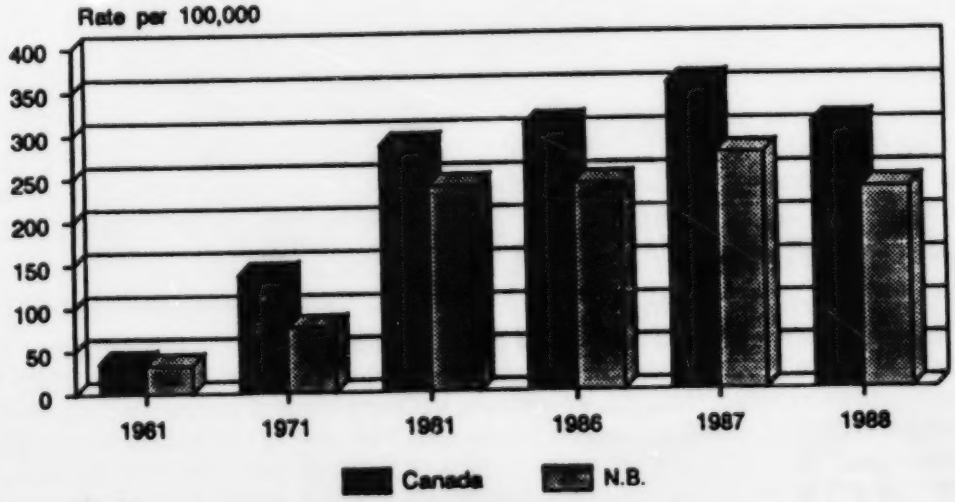

Total Children in private Households: 160,765
L/W Lone parents 19,775 13%
L/W families 136,670 87%
Other 4,320 3%
Living with parents 156,445 97%

Source:

1. The Nation. Families: Part 1 Cat. #93-106 (Statistics Canada) Nov. 1989
2. Statistics Canada. The Nation. Dwelling and Households, Part 1. Cat #93-104

Chart 4

Divorce Rate New Brunswick and Canada 1961 - 1988



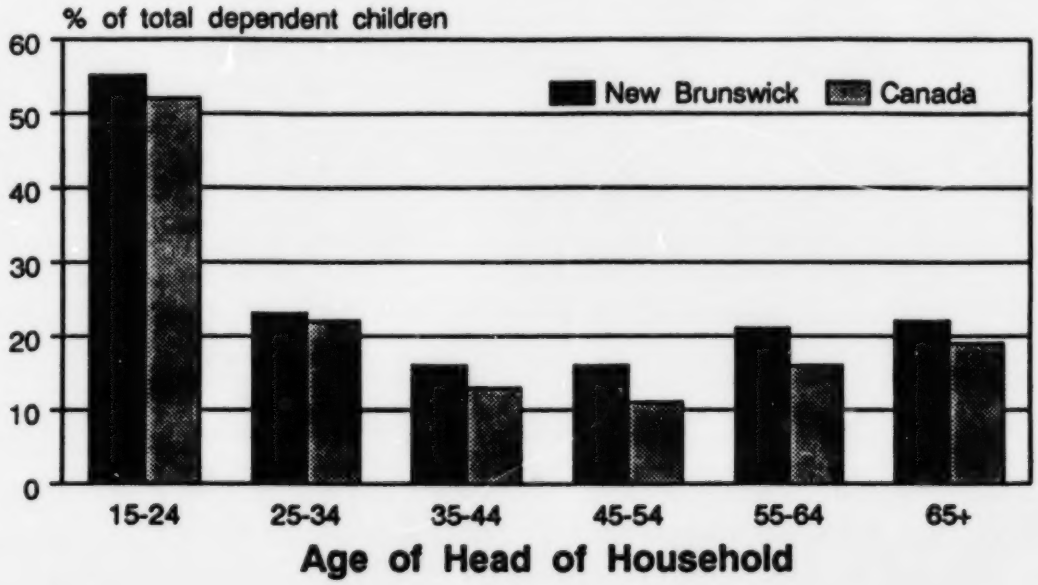
Source:

Statistics Canada - Health Reports Supplement #17 Vol. 2, No. 1 Table 1 p. 2

Source: "Playing for Keeps! Improving Our Children's Quality of Life." NB Office for Childhood Services. April 1991.

Chart 9

Percentage Distribution of Children* of Low Income** Parents, New Brunswick and Canada 1986-87



Source:

Statistics Canada. Survey of Consumer Finances 1986-87 Databases

*Dependent children under age 25
**Based on Statistics Canada Low Income Cut-Offs, 1978 base

Family Size and Low Income

In New Brunswick, as well as in the rest of Canada, families living below the low income cut-offs tend to have more children than other families.[27] Keeping in mind that the presence of children tends to add to the costs which "make families poor", larger families among the poor are nevertheless a contributing factor to the perpetuation of the poverty cycle.

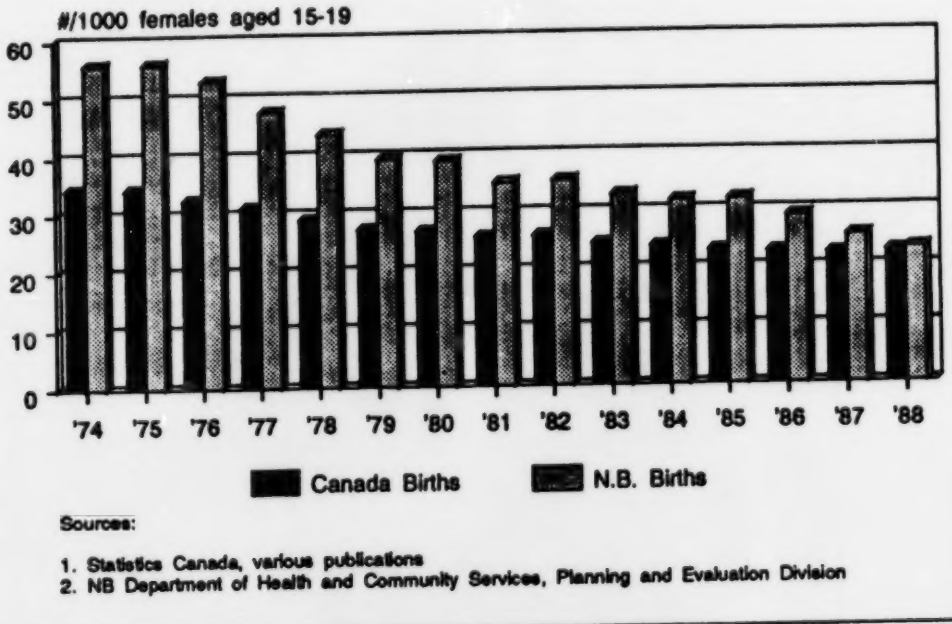
Stay - at - Home Parenting

In New Brunswick, as well as the rest of the country, the option of having one parent stay at home to care for the children has become increasingly less viable. The 1985 Task Force on parents and early childhood, **Voiceless, Vulnerable and Valuable** concluded that there were parents who would opt to stay home with their young children if, financially, they had that choice.[28] For parenting-at-home to be a realistic option, economic barriers need to be addressed and tax structures enhanced which would support parents choosing to stay at home to parent their children. The existing child tax credit indicates a federal recognition of the value of parenting at home, but enhancements to this program are needed to make this a real option.

Source: **"Playing for Keeps! Improving Our Children's Quality of Life."** NB Office for Childhood Services. April 1991.

Chart 5

Births per 1000 Female Population Aged 15-19 for N.B. and Canada 1974 - 1988



Sources:

1. Statistics Canada, various publications
2. NB Department of Health and Community Services, Planning and Evaluation Division

On the other hand, the birth rate for single women 20 - 24 years of age has had a marked increase, at a rate greater than the trend in Canada. The percentage of births to single mothers in this age group increased from 3.9% to 9.3% between 1977 and 1987, compared to a Canadian increase from 3.5% to 7.3% over the same time period.[9] More information is needed on the factors contributing to this trend and its impact on the parents and their children.

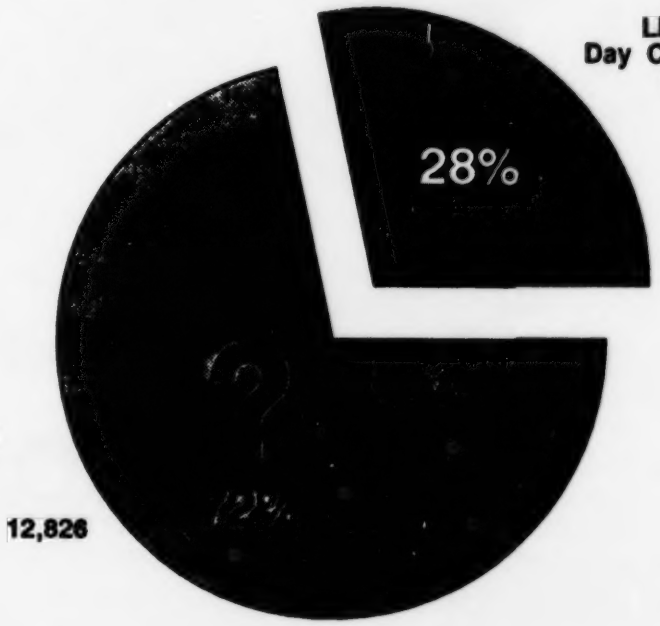
The rate of abortions in New Brunswick for women 15-19 years declined by 8.6% over the 15 year period between 1974 and 1988. In contrast, the rate of abortions in Canada grew by 17% over the same period.[10]

Source: **"Playing for Keeps! Improving Our Children's Quality of Life."** NB Office for Childhood Services. April 1991.

Chart 10

Number of Children (Birth-6) of Working Parents* vs Licensed Day Care Spaces,** New Brunswick, 1989

Total Children Birth to Six Potentially Needing Child Care 17,912



*Working Parents: Parents who are employed at least 20 hours a week or who are full-time students (excludes parents who are employed under 20 hours a week and who attend school part-time).

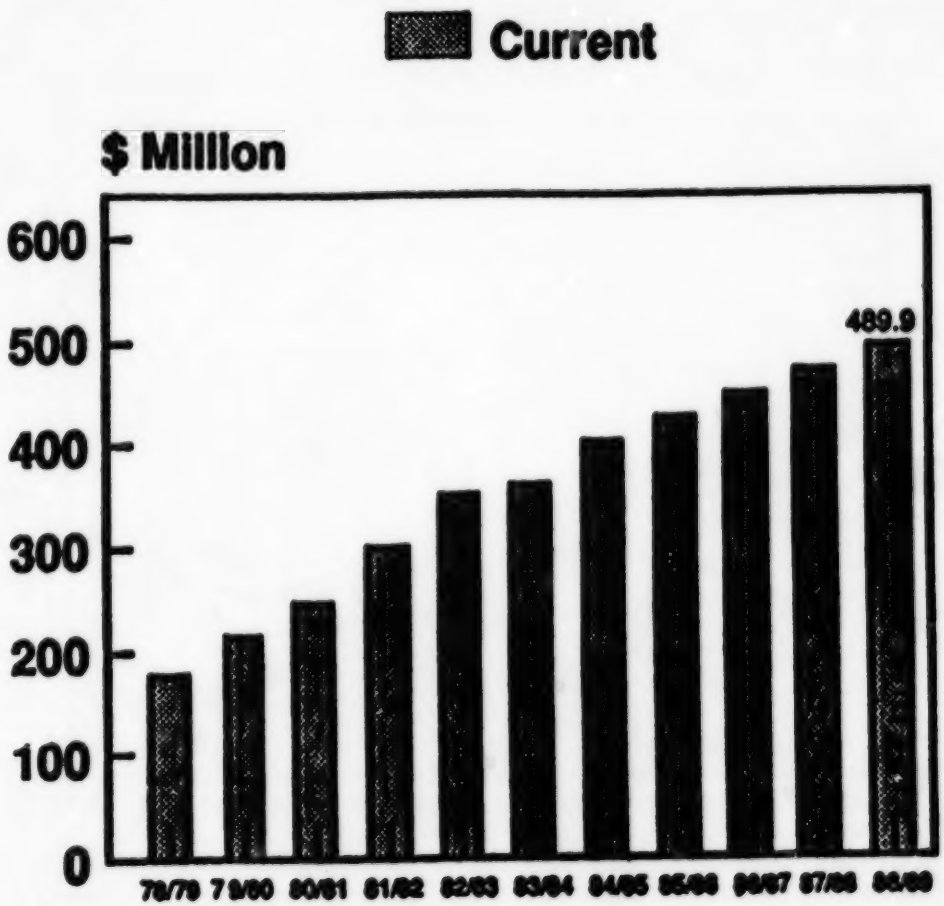
**Licensed day care spaces: Full-time licensed day care spaces, excluding after school spaces, for children under 6 years of age

Sources:

1. National Child Care Information Center, Health & Welfare Canada, March 1989
2. RPSS Information System, Health & Community Services, March, 1989

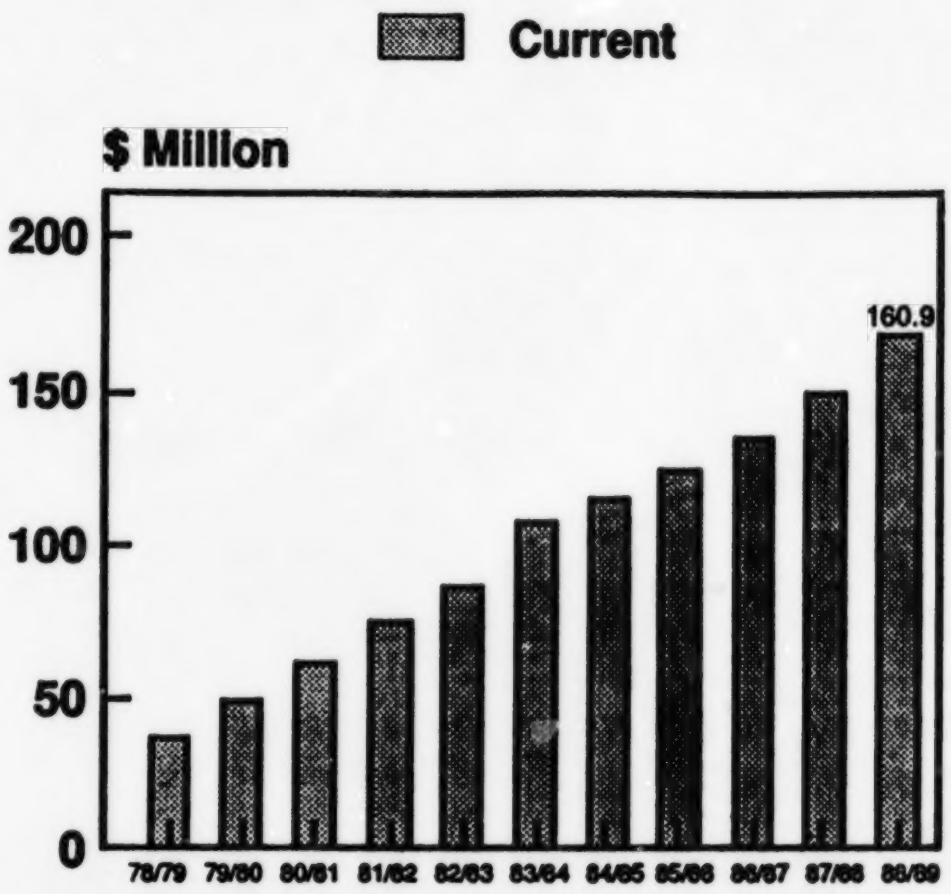
Source: **"Playing for Keeps! Improving Our Children's Quality of Life."** NB Office for Childhood Services. April 1991.

Hospital Operating Expenditures 1978-79 To 1988-89



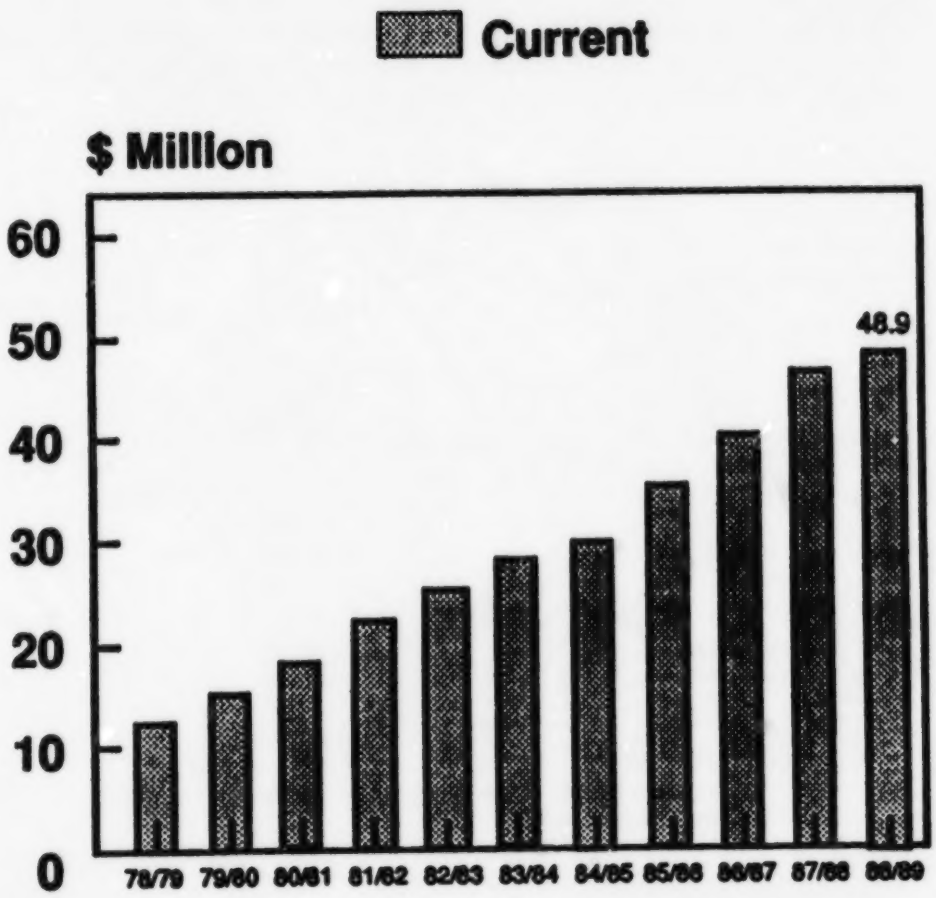
Source: NB Department of Health and Community Services pamphlet

Medicare Expenditures 1978-79 To 1988-89



Source: NB Department of Health and Community Services pamphlet

PDP Expenditures 1978-79 To 1988-89



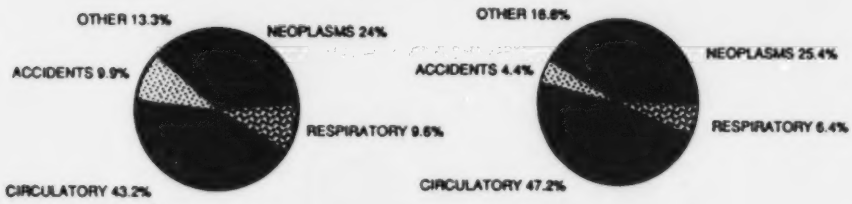
Source: NB Department of Health and Community Services pamphlet

Mortality in the Population

Leading Causes of Death

- On the average 5,233 New Brunswickers died per year during the period 1981-1985.
- The leading causes of death among New Brunswickers were: circulatory disease, cancer, respiratory disease and accidents.
- The percentage distribution of each of these conditions was similar for the period 1981-1985. The graph below shows the percentage of deaths due to these leading causes in 1985 for males and females.

Leading Causes of Deaths
Male and Female
New Brunswick – 1985



Males
Total Number – 3011

Females
Total Number – 2275

- Among males, heart attacks accounted for the largest proportion of all deaths followed by cancer of trachea, bronchus and lung, and strokes.
- The proportion of males who died as a result of heart attacks and cancer of the lung was higher in the south of the province compared to the north during the period 1981-1985.
- Among females, heart attacks, strokes and cancer of the breast accounted for the largest proportion of all deaths.
- The proportion of females who died as a result of these conditions was higher in the south compared to the north during the period 1981-1985.

Source: **"Health Status of New Brunswickers - Highlights."** NB Department of Health and Community Services. 1990.

Circulatory Diseases

Percentage of Deaths Due to Circulatory Disease
Male and Female
New Brunswick – 1985

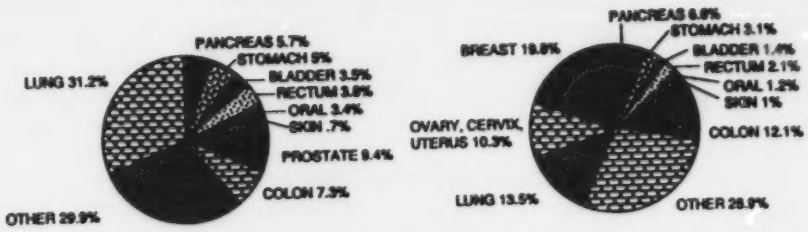
Males
Total Number –1300

Females
Total Number – 1073

- Approximately 75% of all deaths due to circulatory diseases were as a result of heart attacks or strokes. More males than females died from heart attacks, whereas more females than males died as a result of strokes during 1981-1985.

Neoplasms (Cancer)

Percentage of Deaths Due to Cancer
Male and Female
New Brunswick – 1985



Males
Total Number – 726

Females
Total Number – 577

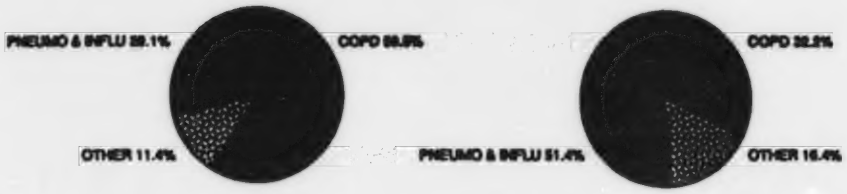
- Among males who died as a result of cancer, the leading cancers in decreasing order were: trachea, bronchus and lung, followed by prostate, colon, pancreas and stomach.

- Among females who died as a result of cancer, the leading cancers in decreasing order were: breast, followed by trachea, bronchus and lung, colon, pancreas and stomach. In addition, when the number of deaths due to cancer of the ovary, cervix and uterus were combined, this cause ranked second in 1983, third in 1981, 1982 and fourth in 1984 and 1985.

Source: **"Health Status of New Brunswickers - Highlights."** NB Department of Health and Community Services. 1990.

Respiratory Diseases

Percentage of Deaths Due to Respiratory Disease
Male and Female
New Brunswick – 1985



Males
Total Number – 289

Females
Total Number – 146

- Chronic obstructive pulmonary disease (COPD) and pneumonia and influenza accounted for approximately 90% of all deaths due to respiratory disease. More males than females died from COPD, whereas more females than males died as a result of pneumonia and influenza.
- Most deaths associated with COPD occurred in the 65 + age group, and the death rate for males was higher in the north for 4 of the 5 years during the period, 1981-1985.

Accidents

- Motor vehicle traffic accidents (MVA) constituted the greater percentage of deaths by accidents during the period 1981-1985. The percentage of deaths due to MVA was generally higher for males in the younger age groups, 15-19 and 20-24 years.

Source: "Health Status of New Brunswickers - Highlights." NB Department of Health and Community Services. 1990.

Morbidity
In the Population

Leading Causes of Hospitalization

- Circulatory disease, cancer and respiratory disease, e.g. COPD were major causes of hospital utilization during 1984-1985.
- Mental disorders were also a major cause of hospital morbidity for females during 1984-1985.
- Males accounted for the largest number of hospital care days per 1,000 population for heart attacks, cancer and respiratory disease.
- Females accounted for the largest number of hospital care days per 1,000 population for strokes and mental disorders.
- Hospital separation rates per 1,000 population for strokes were the same for both sexes.
- Males accounted for a higher rate of hospital separations per 1,000 population for heart attacks and respiratory disease.
- Hospital separation rates were higher for females than males for cancer and mental disorders.

Communicable Diseases

- The four leading communicable diseases reported in the province in 1986 were: gonococcal infections, measles, campylobacteriosis and salmonellosis.
- 506 cases of gonococcal infections were reported (0.7/1,000 population).
- 350 cases of measles were reported (0.5/1,000 population). This was an unusually large number of cases, however, this trend was seen across the country.
- 149 cases of campylobacteriosis (0.2/1,000 population) and 128 cases of salmonellosis were reported (0.2/1,000 population). There were no enteric disease outbreaks.
- The province has a mandatory immunization policy (effective 1982) which requires that all school-age children be immunized at school entry against the vaccine preventable diseases, e.g. polio, diphtheria, measles, mumps, rubella and tetanus.

Source: **"Health Status of New Brunswickers - Highlights."** NB Department of Health and Community Services. 1990.

- 97% of school-age children who entered Grade 1 in 1986 were immunized.

Lifestyle Issues

- Tobacco use and alcohol use among Grades 7-12 students in New Brunswick were 31% and 70% respectively. These substances were used at least once in the 12-month period prior to a provincial study in 1986.

- 31% of New Brunswickers were smoking, and 28% of these were smoking daily, according to the Health Promotion Survey in 1985.

- Alcoholism in males in the province decreased by 5% between the 1971and l981 prevalence estimates. For females in the province, the prevalence estimates of alcoholism increased by 26% in the same period.

- Average annual consumption of alcohol in the province was lower than the Canadian average during the period, 1982-1986.

- The 1981 Canada Fitness Survey showed that activity levels of New Brunswickers were lower than the Canadian average.

- 71% of New Brunswickers always used seat belts when riding in a car, while 9% never used them according to the 1985 Health Promotion Survey.

- 54% of New Brunswickers had their blood pressure checked in the 6-month period prior to the Health Promotion Survey, and 4% never had their blood pressure checked.

- 52% of women in New Brunswick had a breast examination by a doctor or nurse in the previous 12-month period according to the same survey in 1985.

- 49% of women in New Brunswick had a pap smear test in the previous 12-month period, 14% in the previous 2-3 year period, and 19% had never had a pap smear test.

- The percentage of New Brunswickers who would limit or avoid foods for the sake of their health was:

  18% - foods high in cholesterol
  22% - foods high in fat
  13% - foods high in sugar
  7% - foods high in salt (Health Promotion Survey)

Source: **"Health Status of New Brunswickers - Highlights."** NB Department of Health and Community Services. 1990.

AIDS INFORMATION

According to official statistics from the Federal Centre for AIDS, as of October 1991 there are 43 diagnosed AIDS cases in New Brunswick and 151 HIV-positive individuals. The Federal Centre for AIDS estimates that there are between 50 and 100 more persons infected with the HIV virus for each case officially registered. Using the lower figure of 50, we can conservatively estimate a current total of 2,050 New Brunswick residents with the HIV virus.

FACT SHEET ON CHILDREN AND TOBACCO

- Based on recent Health and Welfare surveys, over 90% of young people who smoke report that they started smoking before age 17.
- The largest onset of smoking in Canada is among those 14 years of age and under, with close to 40% of young people who smoke starting before age 12.
- Based on consumption figures obtained under the Access to Information Act, it is conservatively estimated that in 1986, Canadians under the age of 18 smoked over two billion cigarettes, representing an annual market of over $260 million.
- According to the Special Study of Youth (HWC 1988), there are about 500,000 young people between ages 13 and 19 who smoke in Canada.
- Tobacco is a powerfully addictive product. A recent landmark U.S. Surgeon-General's Report confirmed that nicotine is as addictive as heroin and cocaine. The Royal Society of Canada has recommended that tobacco use be classified as nicotine addiction.
- Of all the 15 year olds currently smoking, tobacco use will kill 8 times more than car accidents, suicide, murder, AIDS and drug abuse ALL COMBINED. Tobacco is by far "the real drug problem".
- Public opinion polls indicate that over 80% of Canadians are in support of enforced restrictions on the sale of tobacco products to minors.
- If tobacco use can be prevented prior to age 19, it will be prevented for the vast majority of Canadians, since very few people begin after age 20.
- Tobacco is a gateway drug: research suggests that preventing tobacco use may reduce the potential for other forms of drug abuse.
- Environmental tobacco smoke worsens asthma in children. Infants of parent who smoke have an increased risk of bronchitis and pneumonia.
- The U.S. Environmental Protection Agency has issued a draft report classifying second-hand smoke as a "Class A" carcinogen known to cause cancer.

TOBACCO DEATH CHART

Tobacco kills 35 000 Canadians each year.

Virtually all new smokers are children.

For every 100 000 15-year-old smokers (half girls, half boys), tobacco will kill at least 18 000. The following chart compares tobacco deaths with other causes of future deaths for every 100 000 smokers now age 15:

Cause of Death		Tobacco Will Kill
1 200	Car Accidents	15 X more
900	Suicides	20 X more
130	Murders	135 X more
70	AIDS	250 X more
10	Drug Abuse	1 800 X more
2 310	*All Combined*	*Almost 8 X more*

Source: Canadian Council on Smoking and Health.
Data obtained from the Laboratory Centre for Disease Control, H.W.C.

Table 1

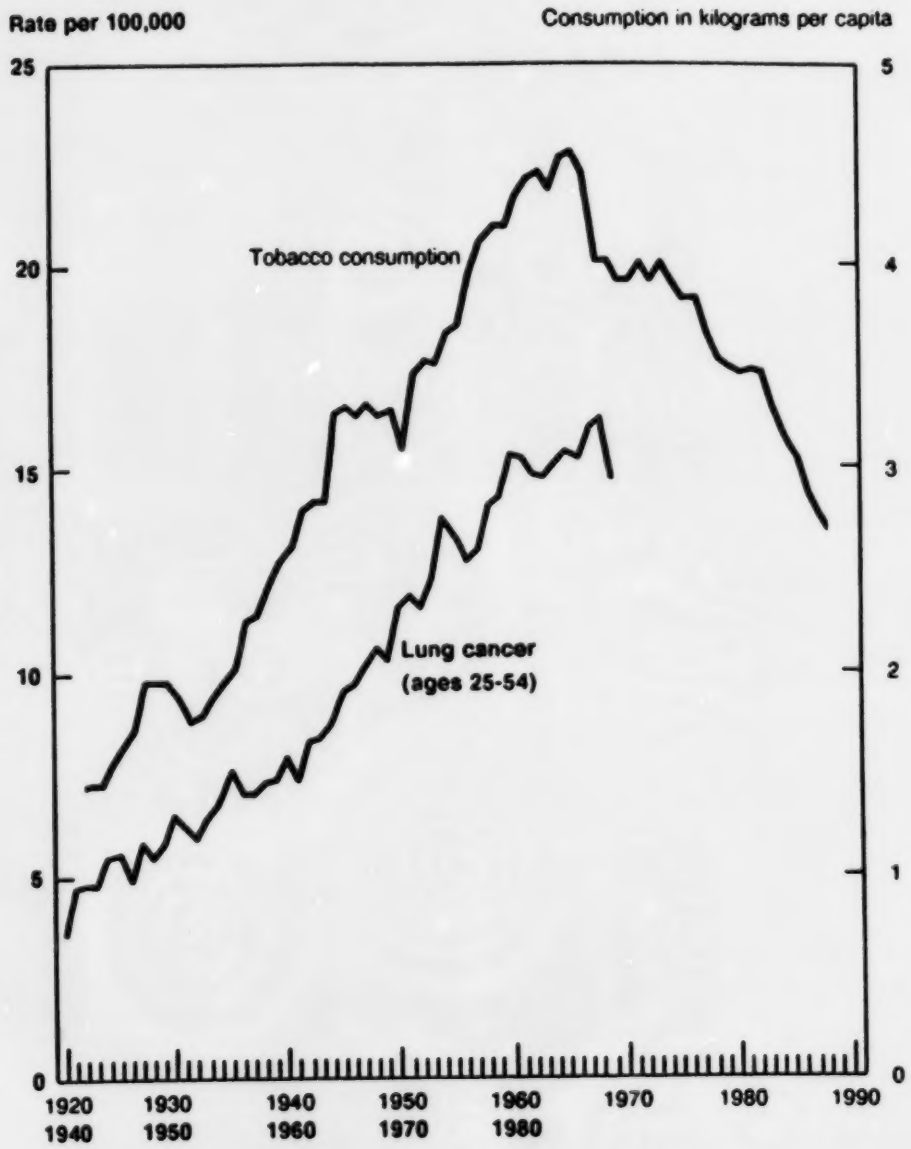
Smoking-Attributable Age-Standardized Mortality Rate and Number of Deaths, and Rate and Number of Years of Potential Life Lost (YPLL) by Province, 1986

	Smoking-Attributable Age-Standardized Mortality Rate per 100,000 and (Number of Deaths)		YPLL Rate per 100,000 and (YPLL)			
	Age 15-74		Before Age 65		Before Age 75	
	M	F	M	F	M	F
Canada*	194	37	857	447	2135	812
	(22791)	(4865)	(1070)	(570)	(2670)	(1040)
Newfoundland	197	36	647	350	1767	635
	(459)	(84)	(18)	(10)	(50)	(18)
Prince Edward Island	205	30	1100	359	2503	628
	(126)	(18)	(7)	(2)	(16)	(4)
Nova Scotia	226	42	913	458	2367	849
	(958)	(181)	(39)	(20)	(102)	(38)
New Brunswick	207	40	865	409	2166	781
	(679)	(138)	(30)	(15)	(76)	(28)
Quebec	229	38	972	479	2436	865
	(6628)	(1331)	(312)	(160)	(781)	(289)
Ontario	184	35	784	411	2044	768
	(7973)	(1729)	(351)	(191)	(914)	(357)
Manitoba	193	39	837	453	2153	821
	(1031)	(211)	(44)	(25)	(114)	(45)
Saskatchewan	169	37	867	448	2055	790
	(865)	(178)	(44)	(23)	(104)	(40)
Alberta	177	40	908	508	1900	848
	(1613)	(413)	(109)	(60)	(227)	(100)
British Columbia	164	37	798	444	1960	815
	(2431)	(560)	(114)	(65)	(280)	(119)

*Figures for Canada include both the Yukon and the Northwest Territories.

Source: Chronic Diseases in Canada, January 1990

Figure 17
Tobacco Consumption from Smoking, 1922-1988 and Lung Cancer Mortality Rates, 1940-1988, Canada



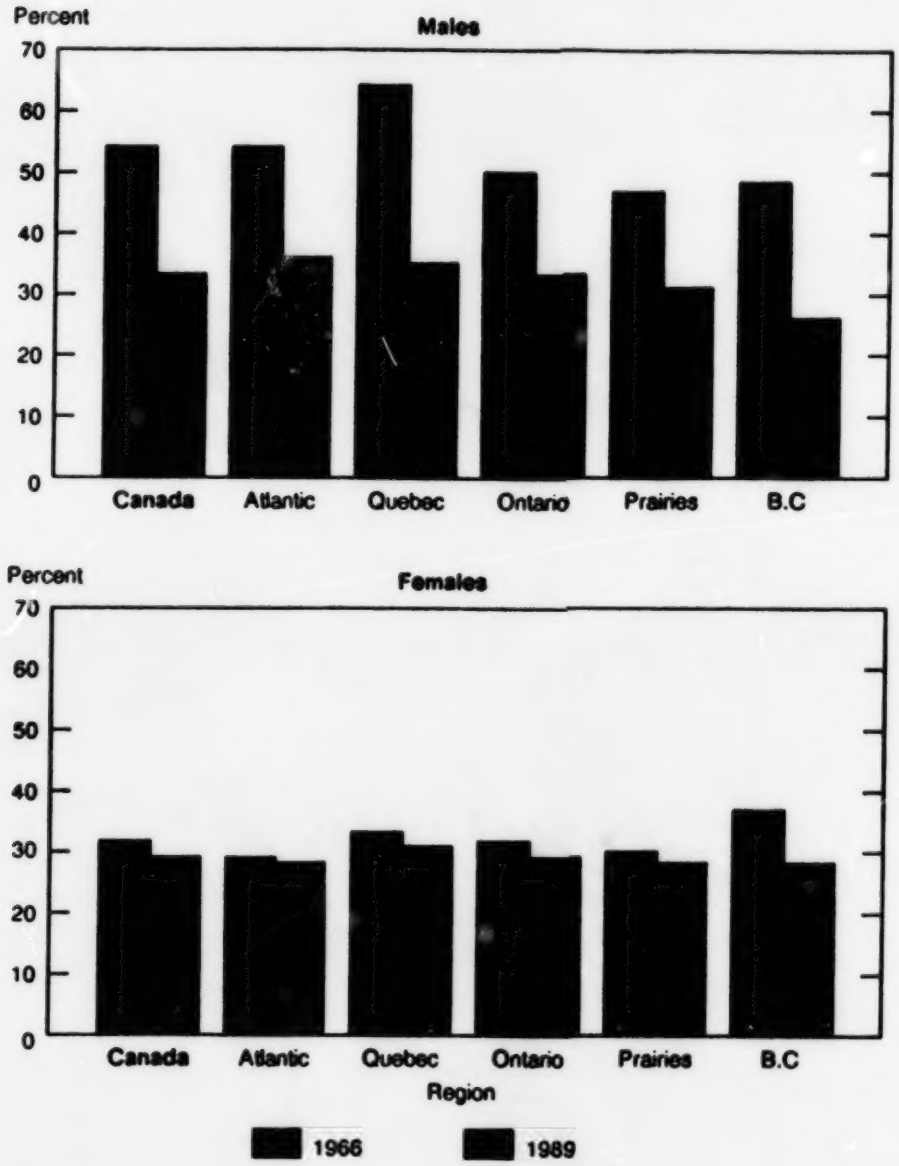
Notes: *Tobacco consumption from smoking was calculated in kilograms per capita (based on population 15 +) and excludes snuff and chewing tobacco.*

Mortality rates are age-standardized to the world population and include deaths for ages 25-54.

Source: *Bureau of Chronic Disease Epidemiology, Health and Welfare Canada.*

Source: **"Canadian Cancer Statistics 1991." Statistics Canada.**

Figure 16
Regular Smokers Age 15 Years and Over, Canada and Regions, 1966 and 1989



Note: *Regular smokers are cigarette smokers who smoke daily.*
Source: *Canadian Centre for Health Information, Statistics Canada.*

Source: **"Canadian Cancer Statistics 1991."** Statistics Canada.

TOTAL ECONOMIC COSTS TO THE PROVINCE

The Alcoholism and Drug Dependency Commission has estimated that the cost of alcohol abuse in New Brunswick in 1988 was in excess of **$249.6 million.**

Economic Costs of Alcohol Abuse to New Brunswick

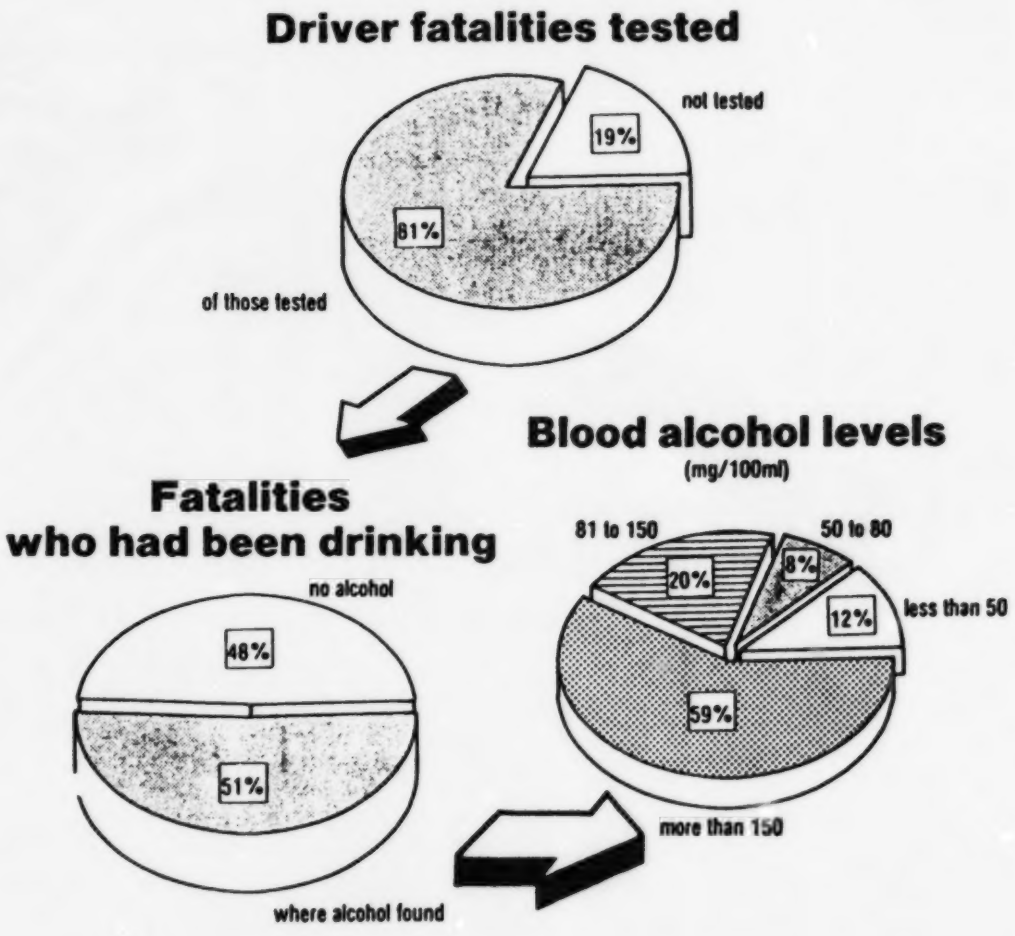
Variable	Estimated Cost in Millions of Dollars
Health Care	109.1
Income Security	49.0
Lost Production	73.1
Motor Vehicle Accidents	2.8
Fire Losses	8.8
Criminal Justice System	6.5
Alcoholism and Drug Dependency Commission	7.1
TOTAL	**$249.6**

Source: The Cost of Alcohol Abuse to New Brunswick, the Alcoholism and Drug Dependency Commission of New Brunswick, July, 1983.(updated November, 1989.)

ALCOHOL RELATED PROBLEMS

TRAFFIC FATALITIES

Alcohol involvement among fatally injured drivers, 1985



Source: Traffic Injury Research Foundation

SOCIAL PROBLEMS

The following statistics from the National Council on Alcoholism show the relationship between alcohol use and crime:

- in robbery cases, 72% of the offenders had been using alcohol;
- in murder cases, 86% of the offenders, and 40 to 60% of the victims had been using alcohol;
- in rape cases, 50% of the rapists had been using alcohol; and
- in assault cases, 72% of the offenders had been using alcohol.

There is growing acknowledgement of the association between family violence and alcohol use, and while the research is scarce, current studies indicate the following:

- alcohol is a factor in 56% of the fights or assaults in U.S. homes;
- alcohol is a factor in 40% of all family court problems;
- alcohol has an association in 34% of the cases of child abuse;
- 50% of alcoholic parents are child abusers;
- 66% of children in alcoholic homes are abused;
- 67% of sexually aggressive acts against children involve alcohol use;
- 80% to 90% of husbands who batter use alcohol;
- 70% of battered women are frequent drinkers;
- 39% of sexually aggressive acts against women involve alcohol use;
- 50% of incest victims are from alcoholic homes.

Source: Focus on Family and Chemical Dependency, Vol. 9,#3, May/June, 1986, pp.10-11.

ESTIMATES OF REPORTED DRUG USE AMONG STUDENTS AS SHOWN IN THE MOST RECENT STUDIES

DRUG	ADDICTION RESEARCH FOUNDATION, ONTARIO 1989	ALCOHOLISM & DRUG DEPENDENCY COMMISSION OF N.B. 1989	S.A.D.A.C. SASKATCHEWAN 1986	B.C. MINISTRY OF HEALTH 1987
ALCOHOL	66.2%	70.9%	66.0%	74.4%
TOBACCO	23.3%	40.9%	31.0%	28.5%
CANNABIS	14.1%	18.0%	14.0%	30.0%
GLUE	1.9%	2.7%		2.7%
SOLVENTS	3.1%	4.4%	1.0%	3.8%
BARBITURATES (P)	7.8%	12.1%		11.3%
BARBITURATES (NP)	2.2%	6.5%	1.0%	
HEROIN	1.2%	2.0%	1.0%	
SPEED	2.5%	5.0%		6.8%
STIMULANTS (P)	3.3%	6.6%		6.3%
STIMULANTS (NP)	6.5%	8.4%	5.0%	
TRANQUILIZERS (P)	3.1%	4.9%		5.0%
TRANQUILIZERS (NP)	2.4%	4.3%	2.0%	
LSD	5.9%	7.9%		
HALLUCINOGENS	4.3%	5.0%	6.0%	14.2%
COCAINE	2.7%	3.0%	2.0%	6.1%
PCP	1.1%	1.9%	1.0%	

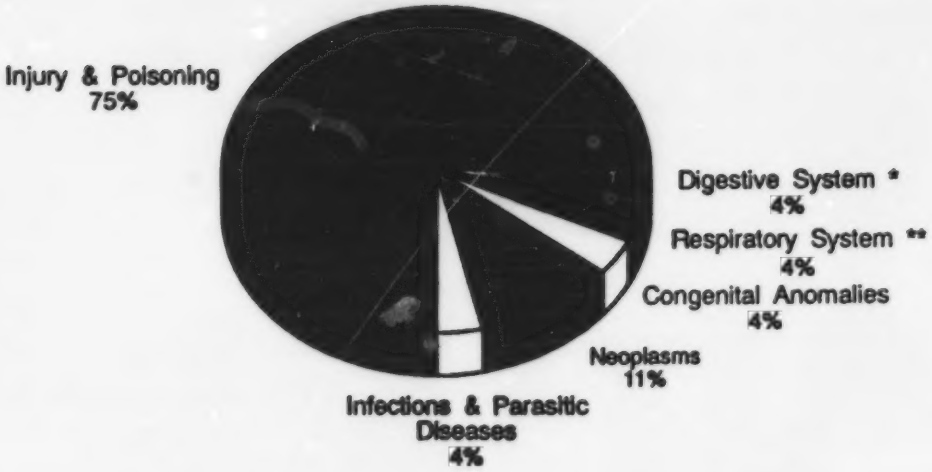
(P) - Prescription

(NP) - Non-prescription

Chart 7b

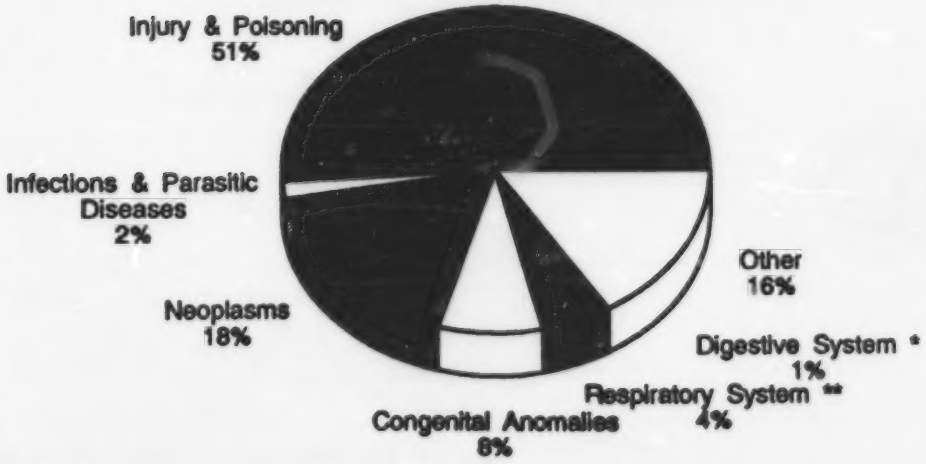
The Leading Causes of Childhood Deaths in New Brunswick, 1988: Comparing These Causes With Canada

New Brunswick
5 to 14 years (n=28)



Source: Health Promotion and Disease Prevention (N.B. Vital Statistics Database)

Canada
5 to 14 years (n=837)

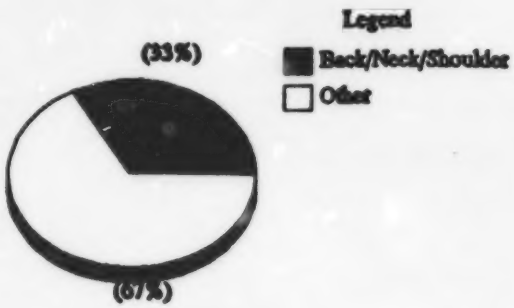


Source: Health Reports. Supplement No.11 1990 Vol.2 No.1.
Note: * Diseases of the Digestive System
** Diseases of the Respiratory System

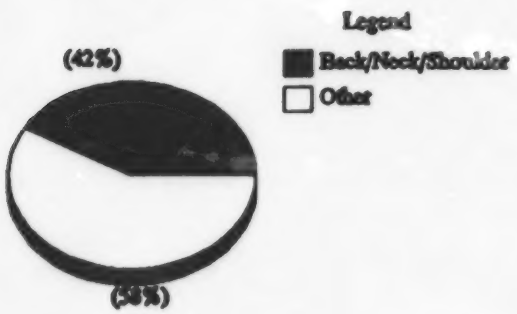
Source: "Playing for Keeps! Improving Our Children's Quality of Life." NB Office for Childhood Services. April 1991.

THE PROVINCIAL PICTURE

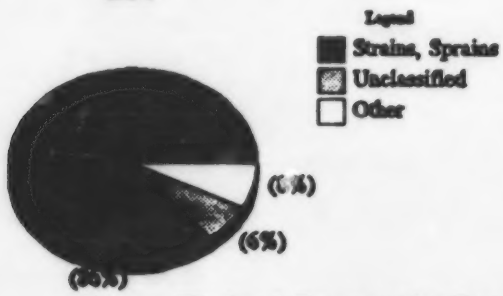
1990 Lost-Time Accidents



1990 Days Lost



Nature of Back/Neck/Shoulder Lost-Time Injuries
1990

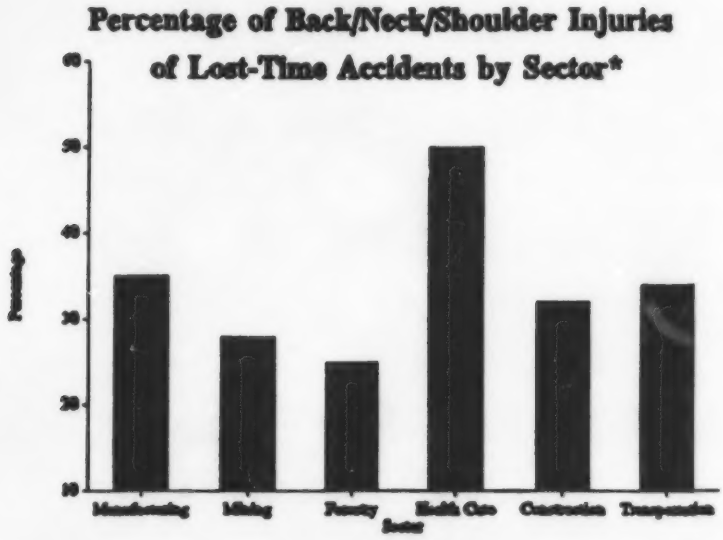


Source: Workers' Compensation Board Statistics

Source: **"Back in Action Program."** NB Occupational Health and Safety Commission. October 1991.

V. HEALTH CARE SECTOR

Following the introduction of the program, it became evident that the Health Care Sector had unique needs with respect to the prevention of musculoskeletal injuries of the back, neck, and shoulder. Accident Analysis revealed the majority of injuries involved client handling.



*1990 Workers' Compensation Board Statistics

COST OF CLAIMS FOR HEALTH CARE SECTOR

	1987	1988	1989	1990	1991
TOTAL HEALTH CARE PAYROLL	$402 mill	$435	$461	$512	$550
ASSESSMENTS PAID TO WORKERS' COMPENSATION BOARD	$7.2 mill	$8.3	$8.0	$10.0	$12 est.
COST OF CLAIMS	$5.3 mill	$7.3	$7.6	$8.7	$9.1 est.

Source: "Back in Action Program." NB Occupational Health and Safety Commission. October 1991.